

Psychodrama and the Psychopathology of Inter-Personal Relations

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FOREWORD

This monograph contains two papers which were in the original form of publication merged into one under the title "Inter-Personal Therapy and the Psychopathology of Inter-Personal Relations," as the opening article of the first issue of *Symmetry, A Journal of Inter-Personal Relations*, 1947.

The first paper, dealing with psychodrama, signified a milestone in the development of its methodology. No other paper on psychodrama has exerted a greater influence since Moreno's *Stegreif Theatre* (Theatre for Spontaneity) in 1923. It has stimulated a mass of ever-growing literature on the subject and the establishment of several Psychodramatic Institutes, the most notable being the Theatre for the Psychodrama at St. Elizabeth's Hospital in Washington, D. C., where psychodramatic methods are applied particularly to problems of diagnosis and rehabilitation of military personnel. It has stimulated similar experiments and studies by other investigators, as within the Boy Scouts of America, New York Public Schools, religious organizations, factories and many colleges and universities throughout the country. It has broadened the concept of the objective interview, in extension as well as in depth, and because of it, freed from an operational doctrine, new versions of psychodrama are continuously being produced.

The second paper, "The Function of the Auxiliary Ego and Inter-Personal Therapy," was one of Moreno's first formulations of intermediate inter-personal therapy. It has proven useful as a preparatory step to psychodramatic research but also independent from it in social and mental problems which require a sophisticated, flexible psychotherapy.

INTRODUCTION

This study presents a novel form of psychotherapy, one which can be applied widely—the psychodrama. Psychodrama puts the patient on a stage where he can work out his problems with the aid of a few therapeutic actors. It is a method of diagnosis as well as a method of treatment. One of its characteristic features is that role-acting is organically included in the treatment process. It can be adapted to every type of problem, personal or group, of children or adults. It can be applied to every age level. Problems in the nursery as well as the deepest psychic conflicts can be brought nearer solution by its aid. The psychodrama is human society in miniature, the simplest possible setup for a methodical study of its psychological structure. Through techniques as the auxiliary ego,* spontaneous improvisation, self-presentation, soliloquy, the interpolation of resistance, new dimensions of the mind are opened up, and, what is most important, they can be explored under *experimental* conditions.

INTER-PERSONAL THERAPY

One of the great problems in mental therapeutics is how to get a patient started. To start the patient expressing himself is a crucial problem even when he comes with a *physical* disease. He has to describe his pains and other experiences related to it. He may hesitate, or put emphasis on insignificant details. It is a part of the physician's skill to start a patient off in the proper direction, so that he may give as precise and objective a description of his condition as possible. This task becomes imperative in the case of psychiatric patients. The patient with catatonic behavior may not be able to get started at all without outside aid, and the manically excited patient may go off on a tangent not amenable to suggestion and guidance.

In all psychotherapeutic situations practised to date, the patient is treated in isolation. He describes with words how he feels about his own problems. But in inter-personal therapy, especially in the form of *psychodrama*, the task is still more complicated. Here he has to be made to express how he feels at present, not only through words, but through gestures and movements. He has to act not only in the role of his immediate situations, but in roles contrasting with his actual aspirations. He has to live through situations which are painful and undesirable, to present roles which are

*See "The Function of the Auxiliary Ego and Inter-personal Therapy" in this monograph, pp 57

obnoxious to him. He has to act with partners whom he loves and admires or whom he fears and rejects. These conditions in the psychodrama have compelled me to reconsider the function of the psychiatrist as well as the function of the patient.

The function of the psychiatrist began to disturb me years ago when I started to use the therapeutic theatre for patients. In his professional capacity, the psychiatrist has to restrain and discipline himself to appear always in the role in which he is expected to appear and for which he is employed, the role of doctor and healer. He cannot leave the role of the doctor and act as a lawyer or as a salesman. The more inflexibly, the more rigidly and obediently he sticks to his role, the higher is his conduct to be commended. Furthermore, even within the role, in the situations in which the doctor meets the patient, many formalities are involved which keeps the situation rigid and the doctor at a certain distance from the patient. This pattern of conduct has to be carefully weighed before altered, even though suggested by an imperative reason.

This imperative reason seems to be given in the treatment of a certain group of mental patients. They are inadequate, at the same time, in many of the roles in which they act in life, as sexual partners, as work associates, as social companions, and alone in their isolated study. To date the psychiatrist with the patient in his office may touch upon and disclose all these roles in the course of his treatment. But however extensively considered they may be, all roles and situations remain "in" the patient's mind. In the office situation, the sexual partner remains fictitious (i.e. something to be imagined) just as the sexual role which the patient feels in himself remains fictitious. Similarly, the work associates remain fictitious, as does he, himself, as a working ego. Other roles and situations which he may feel, and his interrelations with other persons in various roles, remain unenacted. The patient does not move out of himself to incorporate the roles and situations in which he has failed; so the true reality tests are never faced by him in the course of and as a *part* of the treatment. The patient may grow angry at his psychiatrist, he may feel attracted to him as a person. But he may not fight with him, nor express intense love for him. All this remains in the feelings of the patient. The silent drama does not become actual. It is not only that the patient cannot live through the roles and situations before the physician, the psychiatrist himself is limited by the situation in which he is placed. He cannot move towards the patient, get angry, or make love. He is prohibited by a self-imposed pattern of conduct. He cannot transcend his own situation and act a part even if the patient needs it badly. He cannot become "a spontaneous actor." In order

to do this, he would have to give up the accepted, laboriously earned theories and techniques of analytical treatment, and resort to *spontaneous techniques in the treatment of mental disorders*. It is this broader point of view which we are going to discuss in this paper, its greater difficulties, and its greater responsibilities for the psychiatrist.

MENTAL CATHARSIS

The Greek word "therapeutes" means attendant, servant. The earliest therapeutic measure was devoted to driving out the demons from the bodies of the victims. The method usually consisted in the reciting of charms or magic over the ailing parts or over the sick person, as a whole. The patient, as he was not able to drive out the demon himself, needed an attendant, or servant, a therapeutes. The recital of magic or charm over the sick person was performed by a priestly man, a primitive counterpart of the principal therapeutic actor, the auxiliary ego, in a theatre for the psychodrama. The drama, long before it was a place for presentation of art and entertainment, was a place for therapeutics, the sick coming to it for catharsis.

Aristotle defines catharsis in his *Poetics* as follows: "The task of the tragedy is to produce through the exercise of fear and pity liberation from such emotions." Aristotle expected the catharsis to take place in the spectator. The modern point of view as explored by me is in contrast to Aristotle's. The mental catharsis which we expect is to take place in the actor, in the mind of the person who is suffering from the tragedy. The place of catharsis has moved from the spectators to the stage. They, the actors, are the patients, they need catharsis, liberation from the tragic conflicts, from the emotions in which they are caught. But if the actors are the subjects of the catharsis, then the whole process on the stage has to be reconsidered. Aristotle's tragedy was a *finished* work, finished by an author, an outsider, long before it was enacted and without any relationship to the personal make-up of the actors. It is clear that the tragedy, to be truly cathartic material has to be created by the actor-patients themselves out of their own psychic stuff, and not by a playwright. The actor-patients can of course become authors of their own drama, and rehearse it in collaboration ahead of time. That may give us a better insight into the personal problems, but its actual presentation on the stage after weeks or months of labor, censoring and erasing of material, would add little or nothing to the mental catharsis already attained by the writing of their play.

We have to go one step further. Not only the author, but also the finished tragedy of Aristotle, has to be discarded. The actor-patients should have no given product to start with. They should develop their drama

PSYCHODRAMA

on the spur of the moment. The problems portrayed, whether they are their own personal problems or whether they are fictitious, have to be shaped as they emerge spontaneously. The possibilities of insight into and mental catharsis of the patients are then practically unlimited. Into the place of Aristotle's tragedy steps the *psychodrama*.

With it the problem of mental catharsis has changed. As in a tragedy, the participants in a psychodrama may be numerous. The catharsis in one person is dependent upon the catharsis in another person. *The catharsis has to be inter personal*. As the course of interaction between the persons is partly spontaneous, the amount of maladjustment between them will be no accident as well as the amount of mental catharsis attained.

THE PSYCHODRAMA

Let us go back to the first experimental device which we constructed in the early days of *stereif-work*,* and look at it from the therapeutic angle exclusively. What concerned us primarily in the pretherapeutic, purely dramatic phase was the momentary structure of a situation, and how to get the individual started so that he might throw himself into that momentary state. The momentary structure of a situation for spontaneous dramatic purposes, whether suggested by the director or the actor himself, consisted of an imagined situation carefully specified, of a role for the individual actor, and of a number of personified roles by other actors needed to bring the momentary structure to as clear and dramatic an experience as pos-

* *Stereif* is a German word difficult to translate. One translation is 'stirred up' or 'stirring up quickly,' another is 'get started,' another "acting on the spur of the moment." If we take the term '*stereif theater*' it means a theatre which is dedicated to the spontaneous drama. I chose this name for the experimental stage which I started in Vienna during 1921. Its stage between 1921 and 1924 had two lines of development. The first was purely dramatic drama in all of the drama of the moment. It created a new form of the drama, the 'living newspaper.' The other line of development was purely therapeutic, the study and treatment of mental problems through the medium of the spontaneous drama. Similar demonstrations were made in London and in Zurich, Munich and Berlin. The work was continued in New York during 1925-26 at the Episcopal Church Brooklyn, and at the Mt. Sinai Hospital in New York, at the General Serrano House New York, and in Hunter College in 1929. In 1930 the experimental theatre was located in Carnegie Hall which gave a special evening performance through it to Theatre Guild in 1931, in the form of a living newspaper. From 1930 on many other institutions have made use of my technique. A series of these papers were published at the New York State Training School for the Feeble-minded, at the New York problems of social maladjustment, vocational training, and education. It was the theatre at Beacon Hill, Beacon, New York, a modern experiment of 1934.

sible—all this to be brought into action on the spur of the moment. The momentary private life situation of the actor, his private personality and the actual strivings and conflicts which were for him just in the process of development were less emphasized in our dramatics classes though they became of particular concern in the case of mental therapeutics. Then the momentary structure of the patient's private life situation, the physical and mental makeup of his personality, and, most of all, how he operated and interacted at that moment with members of his family and with various members of his "network," was the information needed for diagnosis. More accurately it was needed by the patient and his auxiliary ego, the psychiatrist, in order to devise some vehicle of autonomous treatment and cure. We realized that he must have charged and tainted all persons and objects of his immediate environment with some aspect of himself, and that this must be traceable in the performance of his bodily and mental functions, in his inner tensions preliminary to these performances, in his gestures and expressions, in the words associated, and in the feelings and movements towards the persons and things with which he lived. Considering the more complex forms of social neurosis, when two, three, or more persons were to be treated simultaneously, the scenes enacted between them became a formidable pattern for treatment. Finally, all the scenes in their remote past, and all the remote networks, became important from the point of view of a general catharsis of all the people involved. The solution was then the resurrection of the whole psychological drama or at least of the crucial scenes of this drama, re-enacted by the same persons in the same situations in which their association had begun. The new technique, if properly applied, aided the patient to actualize during the treatment that which he needed to let himself pass through in a procedure which was as close to his own life as possible. He had to meet the situations in which he acted in life, to dramatize them, to meet situations which he had never faced, which he evaded and feared, but which he might have to meet squarely one day in the future. It was often necessary to magnify and elaborate certain situations which he was living through sketchily at the time or of which he had only a dim recollection. The chief point of the technique was to get the patient started, to get him warmed up so that he might throw his psyche into operation and unfold the psychodrama.

A technique of spontaneous warming up to the mental states and the situations desired was developed. The spontaneous states attained through this technique were feeling complexes and, as such, useful guides toward the gradual embodiment of roles. The technique demanded usually more than one therapeutic aid for the patient, such as aids to start off the patient

himself and representatives of the principal roles the situation and the patient might require. Instead of one, numerous auxiliary egos were needed. Therefore it lead to this: the original auxiliary ego, the psychiatrist, remained at a distance but surrounded himself with a staff of auxiliary egos whom he co-ordinated and directed and for whom he outlined the course and the aim of psychodramatic treatment.

PSYCHODRAMATIC METHOD

Procedures of the treatment may be *open* or *closed*. The open treatment is carried out in the midst of the community more or less with the full knowledge and eventually with the participation of the group. Treatment for sociometric assignment is an illustration of open treatment. It is treatment *in situ*. The scene of treatment is the same for the patient as the scene of his living. It is the essence of sociometric treatment that the social situation of the patient and the therapeutic situation of the patient are one and the same. The surgical operation is an illustration of closed treatment. The patient is removed to the hospital and only the surgeon and his assistants participate in the operation. Similarly, psychodramatic treatment is at times closed. The patient is taken out of his immediate environment and is placed in a situation especially constructed for his needs. The therapeutic theatre is such a situation. It is a world in miniature. It is a place in which, through psychodramatic means, all situations and roles which the world produces or may produce are enacted. The situation is closed because there is no room for spectators other than the community of auxiliary egos. Only the psychiatrist and a number of assistants who are assigned to principal roles in the course of the treatment are in the theatre. There are forms of psychodrama which are wide open, for instance, when the audience is made up of numerous subjects, sharing in the same mental or cultural syndrome. The audience, however large, is then like a collective patient, consisting of individual components.

At times the psychiatrist himself should be a subject in the psychodramatic study. A staff of auxiliary egos is informed of the specific situations in which the patient might act. The staff of therapeutic assistants should be as large as possible. It should contain members of both sexes and should vary widely in personality types. The patient at first mixes freely with all the members of the staff. He has an opportunity to become acquainted with everyone. He may be attracted to some and repelled by others. The patient is given the choice of the role and the choice of the assistant with whom he would like to act out the situation. The tele relations of the patient are thus our first guide. The patient is allowed to carry

out his personal aims to the extreme. Every situation and performance is analyzed immediately after the performance in the presence and with the collaboration of the patient. After a number of situations chosen by the patient have been enacted, it may become evident that he tries to avoid scenes and roles which are painful and unpleasant. Then the moment comes when it is necessary to tell him in what situations and in which roles he should act.

The therapeutic approach differs thus from the artistic approach in one essential factor. It is concerned with the private personality of the patient and his catharsis, and not with the role represented and its aesthetic value. However, we shall see later that the therapeutic and aesthetic domains cannot be separated forever, that they have a definite interrelationship.

When we apply psychodramatic principles to art, especially in the theatre, one notes that the presentation of the role is often interrupted by foreign elements, betraying the private personality of the actor and many of his own traits and desires. The spontaneous character of psychodramatics makes it hard, almost impossible, for the actor to keep his private ego out of the role, and he is, perhaps, continually forced to mix the private role elements with collective role elements so skilfully that no one can tell the difference. When a role is rehearsed as in the theatre, these adjustments can be made with more consummate perfection, and a gradual elimination of all the painful, unpleasant elements incongruent to the role can take place. It is just the imperfection of the individual in psychodramatics which makes it so invaluable for the analysis of personality.

THEORY OF ROLES

The role can be defined as a unit of synthetic experience into which private, social and cultural elements have merged. Since time immemorial the theatre has been the most extraordinary setting of role-acting. In the drama the platonic idea of the role was cultivated in its pure form, unadulterated by the fragmentariness and complexities of real living. It was plausible therefore, that psychodramatic theory should rediscover the role phenomenon and it was the psychodramatist's good fortune to open for the role process the gates to experimental and clinical foundation. We were thus able to render a service to the sociologist and social psychologist who were trying in vain to give a tangible and scientifically verifiable basis to the process of role-taking. Every psychodramatic session demonstrates that *a role is an inter-personal experience* and needs usually two or more individuals to be actualized.

PSYCHODRAMATIC TREATMENT OF MENTAL PROBLEMS

TECHNIQUE OF SELF-PRESENTATION

The simplest psychodramatic technique is to let the patient start with himself, i.e., to live through in the psychiatrist's presence, situations which are a part of his daily life, and especially to live through crucial conflicts in which he is involved. He can also enact and represent as concretely and thoroughly as possible every person near him near to his problems, his father, his mother, his wife or any other person in his social atom.* The patient himself plays the role of the protagonist of the treatment. It is not the father, the mother, the wife or the other person, *as such*, rather, *his* father, *his* mother, *his* wife, *his* mother, etc. The patient himself is the center of the staff in setting up the situation, and the auxiliary ego's are outside the situation. The auxiliary ego's be outside the enacted situation, but be in contact with the social atom itself. He is in the theatre and is one in front of whom the patient acts. The relationship of the patient to his auxiliary ego's is clearly based on the structure of the psychodramatic presentation. He watches the patient's behavior, encourages him, and makes comments. At times the patient stops and explains his acts to him. The patient may act the same situation differently to a man, to a woman, to a person attracted to him and to a person indifferent to him.

The presentation can relate to situations past, present or future. The patient is asked not merely to portray situations which he has lived, but to duplicate them completely. He is also asked to portray those situations with as much detail as possible, in collaboration with a partner if necessary. If he is in the situation, a free character he may psychodramatize them alone. But if the patient has certain concrete partners in mind, his wife, his brother, or someone else, then it is desirable to have these imagined concrete partners present and work out the situation with him on the stage. If the concrete person he imagines is not available, he is asked to pick from among the persons present someone he imagines resembles the partner. If the patient has dreams, he is asked to psychodramatize the dreams as accurately as possible. It is desirable that the patient be prepared by the psychiatrist by a number of auxiliary ego's for these projected situations.

*The concept of the social atom of the individual is that a person is emotionally related to a number of others at the same time. It is the emergent nucleus of the social atom. The person is in contact with a number of others. The social atom is the sum of the contacts of the person. It is therefore also called the total social environment. It is at the center of the social atom in the formation of the person.

A CASE OF ANXIETY NEUROSIS, COMPLICATED BY MATRIMONIAL CONFLICT

Robert is a patient who illustrates this type of treatment. After a few office interviews he is invited to the theatre. He acts himself and he enacts every member of his immediate environment, of his social atom. He tries to show how he acts in key situations towards them, and to show how they act in key situations toward him. Then he tries to show how they act in key situations towards one another. He attempts to live through these situations as accurately as possible. In this technique, the patient is not only himself, but also his own assistant. The patient himself becomes the auxiliary ego. He presents himself one-sidedly and subjectively, and he presents the different people of his environment one-sidedly and subjectively, not as they *are*. He acts his father, his mother, his sister, his wife, and any other member of his social atom in full subjective one-sidedness. The emotional currents which fill the social atom are re-enacted by him and made alive. The balances and imbalances within his social atom may then find a catharsis in his psychodrama.

*Situation** Robert enacts himself

The patient is prepared by a member of the staff. He is told: "Portray yourself, how you acted in any recent situation which seems significant to you." He chooses to present how he acted toward his father three days earlier.

The dialogue was recorded by a dictaphone. The gestures and movements accompanying the dialogue was recorded by a member of the staff in the course of the procedure.

Gestures and movements

Walks restlessly up and down from the higher to the lower level. He murmurs a few words, inarticulately. Instead of starting to act, he speaks to the psychiatrist.

Urged again to act, he warms up to a rudimentary state, moves vehemently towards one of the columns on the stage, but does not utter a word. After a pause, he begins to talk. It is in the form of a monologue, listless.

Stops suddenly. Walks off the stage with a gesture of embarrassment.

Dialogue

I don't remember anything. I can't do it.

Father, you should not rush, you rush yourself to death. You should try to get along with mother, etc.

Immediately afterwards, he tries to show how he had acted towards his mother recently—he exhibits a behavior similar to that described above.

*The material used in this paper is only a small part of the total material which each case produces.

ANALYSIS

The psychodrama here was in itself little productive, but it warmed up the subject to a sufficient degree as soon as it ended.

The patient explained that he found it blank that what he did was all wrong. Whenever he began to think, the idea of another situation entered into his mind and interfered. It was a scene which he had had with his wife that morning before coming to Beacon Hill. He felt uncomfortable as he tried to portray himself as he told his father and his mother. He felt pain around the heart, in the chest, and in the preparation.

The patient had difficulty in letting it start. This was surprising because in the office he was able to talk about his father and mother and volunteered information about his relationship to them. Apparently for him the indirectness with words and ideas came far easier than their direct psychodramatic three-dimensional presentation. The fictitious presence of father and mother was far more real when he had to portray his feelings towards them in full physical and mental action. The dread of doing it became so great that it hindered his warming-up process. Besides the dread of the psychodrama in which he had to act as if he were face-to-face with his parents, another factor was significant—the preparation for the situation. I prepared him for the situation with his father. Robert might have done better work if prepared by someone else, perhaps by a person whose authority is less felt by him. The factor of clucking and of interpersonal argument comes into bearing here. Further, the preparation of the patient was casual and rapidly done. He might have done better work after more thorough preparation. In some cases in which a complex is ready and mature for psychodramatization the patient can start himself off. Preparation by an auxiliary ego is unnecessary. But the same patient may have difficulties in turning another complex, referring to a part of his psyche which he does not like to exhibit. In general, the greater the patient's dread of psychodramatizing some function of his psyche, the greater is his need for an auxiliary ego to start him off. Some people do not like to expose their body, perhaps, some parts but not other parts, some patients do not like to put certain parts of the psyche on show. They may feel that these parts are ugly and repulsive. Psychodrama is here a counterpart of nudism. The dread of warming up may become manifest in the simplest tasks—tasks which the patient performs in life spontaneously and with great ease. He may cling to a certain spot on the platform as if he were nailed to it unable to rise and express himself. The work of the auxiliary ego in warming up the patient must change with the type of task and with the type of mental disorder involved.

The patient, having started poorly, finished prematurely. In fact it was a pseudo-finish. He was not able to develop a full spontaneous state, and without a spontaneous state a true finish is not possible. He rushed one word after another without any feeling accompanying them. There was an excess and waste of gesture apparent and the movements from one position to another in space were not motivated.

Situation Robert enacts his father

The patient is prepared by a member of the staff. He is told "Portray your own father. Feel yourself into him and show us what your father is like. Portray him in any situation which seems to you to be crucial and characteristic of him. Choose a situation which really happened and which occurred as recently as possible. Show him as he acts towards your mother, your sister, your wife, yourself, or any other significant person." Robert begins to show how his father acts toward his mother

PROCESS

Gestures and movements

Warms up easily. He acts promptly. The acts are short, about half-a-minute to one minute long. The scenes are packed with short sentences. Sometimes he breaks a scene off abruptly, and sketches a new one which just comes to his mind and which seems to him more characteristic. When he is through with the sketch, he does not relax, but moves restlessly around in space, and as soon as he has an idea he takes position. At times he stops and says

After the words (acting in the role of his father) "I have to make a telephone call," Robert stops playing his father and says off scene, "That is not my father, that is me."

Then he starts anew

Robert returns to the stage and enacts the following scene

After the sentence, "Close the windows," he stops acting his father and says again off scene, "That's me again, not my father."

Dialogue

"It was not like this. I will do it again. Now I have something which is characteristic of him."

"Is the dinner ready? It is not? If I come home at seven o'clock it is not, if I come at midnight, it is not, a meal is never ready in this house (Meal is served) I cannot eat. *I have to make a telephone call.* Hello! Mr. S? Wait for me in the lobby. I will be there in a few minutes." (Begins to eat and interrupts himself. Makes another telephone call.) "I will be right over. It is business. I have to run." (Leaves the meal and rushes out.)

"What a draft in this room. What a house. *Close the windows.* I feel the wind on my back. I am also living here, not only you." (Takes his hat and rushes out.)

"How much money do you want? Always money. You can spend it all right. I can't give you \$75.00. I don't make

of them. So he understands both of them. But he understands his father better. He sides with him rather than with his mother. Probably this was one of the reasons why it was easier for him to start portraying his father rather than his mother. Once they had separated and had lived apart for many months. He, the oldest son, tried to harmonize them. He understood the feeling of both and he succeeded in bringing the father back home, but that did not help. They lived together, but like two enemies in the same house, a continuous source of mutual irritation.

When he enacted his father he discovered that he felt just like his father about his mother and when he enacted his mother he discovered that in some respects he felt just as his mother did. When he portrayed his father he used the phrases which his father used, but that is as far as he went with the portrayal. It was his own voice speaking, most of the feelings and gestures were his own. The roles of his father and of himself were mixed.

He was not able to enact himself in a role in a situation with his father, but he was able to do so with his late Uncle John, the older brother of his father, censuring him—"Why don't you take your time, you rush yourself to death. Sit down and listen. A new client? Call him up and tell him that you will see him tomorrow."

TECHNIQUE OF SOLILOQUY

I have shown in another paper* that the auxiliary ego is able to contribute a new element to inter-personal therapy. He determines the unspoken feelings and thoughts which two persons who are bound up in an intimate life situation have for one another, and completes the picture of the other in both minds. The problem of technique is to enable the auxiliary ego to overcome the inherent tragedy of our inter-personal world. Yet the insight which one person has about what goes on in the other person's mind is at best sketchy. We live simultaneously in different worlds which communicate only at times, and even then incompletely. The psyche is not transparent. *The full psychodrama of our interrelations does not emerge, it is buried in and between us.*

Psychodramatics has had to develop a number of techniques to bring deeper levels of our inter-personal world to expression. One of these techniques is soliloquy. It has often been used by dramatists for artistic purposes, as by Eugene O'Neil. But in psychodramatics soliloquy has a new meaning. It is used by the patient to duplicate hidden feelings and though s

*See pp 57

which he *actually* had in a situation with a partner in life or which he has *felt* in the moment of performance. Its value lies in its truthfulness. Its aim is catharsis.

Both husband and wife are in the theatre. The psychiatrist and two auxiliary eyes are present. In the following psychodrama we see man and wife acting out some by side some feelings and thoughts which they had in a few situations in regard to each other. They were themselves taken by surprise upon seeing and hearing what the other party had felt but was fully unexpressed.

Situation: Robert is not himself in a situation with his wife, Mary, his wife, acting as his partner.

The patient and his wife are prepared by a member of the staff. Robert chooses the situation which had been on his mind in the first session and which had bothered him then - a scene with his wife on the morning he came to Beacon Hill. He and his wife are told: "Portray the scene exactly as it happened, but in addition also the feelings and thoughts which you had at that time but which you did not express. Express them now in movement and gesture. Speak them out now in a lower voice - in soliloquy."

PROCESS

Co-actors and movements

Robert and Mary trying to reconstruct the situation, discussed in some details. He thinks that she had been with him in the living room, not doing anything. Finally they agree that he had been working in the kitchen when she was packing a suitcase. They divide the stage into several parts so that each can duplicate the spatial arrangement of those participating. He, the husband, occupies the center, left facing the right, bedroom in the back. He then walks up and

Dialogue

Soliloquy

MARY (from bedroom)
What are you doing, Robert?
Robert: Clearing up the
table. I will wash the dishes.

MARY: Let me do it.

Robert: No. I will. Sure
I have plenty of time to
get to Dr. Moreno. It is not
twelve o'clock. We have till
11:30 to go.

ROBERT: We have to hurry.
We have to hurry. I hope
nobody calls me up now. Con-

*Gestures and movements**Dialogue**Soliloquy*

ROBERT—Every other moment takes his watch from his vest pocket, and looks at it

Robert washes his hands, washes his face and powders it, again tense Packs his suitcase Mary packs her suitcase

MARY—Where is the suitcase?

ROBERT—Oh, I have packed everything already Don't worry We have plenty of time

Mary tries to put her dress in Robert's suitcase

sidering what might happen, little time is left I need a shoe-shine I need a tie That is necessary to look right If I rush down town to get this, little time will be left I'm afraid we won't be on time at Dr Moreno's She never puts things in the right place Here she puts a glass that belongs on the top shelf Here she puts the dishes I have to wash them for her Otherwise we would never get there Hurry, hurry! She is wasting time

MARY—He is so restless Why didn't he let me wash the dishes?

ROBERT—She's to blame if we are too late

ROBERT—I am all packed
MARY—Never mind I see that you have done all my work

ROBERT—Oh, I just put the glass in the ice box I took the milk bottles downstairs I put the soap where it belongs

ROBERT—I didn't want to leave the ashcan there for the week-end It should not be there It is full It should be empty So, I took it down

Robert washes his face and powders his face and combs his hair a second time

ROBERT—I hope nobody calls me

Telephone rings Robert answers

ROBERT—Who is there?
Four people? I will be right over

(To Mary)—I must go to the office I will be right back

Exposition and introduction

Takes his hat and coat,
 walks at and takes on the
 walk to the office

Dialogue

PEPPER: I am late for
 my appointment.

In his office

ROBERT: What is it? Let
 the two people in. Well, you
 have to pay \$12.00. Can
 you afford twenty dollars a
 week?

Soliloquy

ROBERT—I have to be at the
 office at twelve. At twelve-
 thirty at the dentist. How am
 I going to take care of four
 people in a half hour? At
 1:45 I should be home for
 lunch. The dentist will cer-
 tainly keep me longer than
 15 minutes. At 1:15 I should
 be at the bank to draw out
 money. At 2:00 to meet the
 new attorney. Then I should
 let a short time and buy a
 tie. I should stop at the gas
 station. The car should be
 gone over. It may need a new
 tire. I do not want to have
 an accident. I should start at
 2:20 to be at Dr. Moreno's
 on time. The last train goes
 at 2:45 on Tuesday. If I miss
 that one, the next train is at
 three. But I can't be at Dr.
 Moreno's until 5:15 and I
 should be there at 5:00. I
 don't see how I can get there
 on time if I do all the things
 I'm expected to do.

ROBERT: Oh, I never have
 any peace from these people.
 They always come at the
 wrong time. It's terrible. We
 have to see them. I will be
 late to go to Dr. Moreno's.
 I won't get there. Something
 will have to be done. It's ter-
 rible. They will have to go.
 I must see the doctor. We
 must hurry.

PEPPER: About that lot
 of Well, it's worth three
 lots at 1000 each right? Who
 else is there? Can you tell
 me? Glad to see you. Well,
 the mortgage is Mordecai
 mortgaged at 11:00. I'll be there
 together.

If counts order and
 not paid her. If not
 But be slow to his hand

ROBERT: The More - We
 have to hurry. Well, it is
 true we still have three min-
 utes. That's pretty close
 and it. Let's go. Mary come

ANALYSIS

There was a slight difficulty at the start. One tried to remind the other of something the partner had forgotten, and they corrected each other's memory easily. The actual situation had taken place about 28 hours before the soliloquy. It would appear that the nearer the situations are to the present, the more accurately are they remembered, and the more correctly can they be enacted.

The patient, Robert, and his wife Mary, were both eager to dramatize that situation. It brought them relief, particularly the soliloquy. The patient had been uneasy at first about the use of soliloquy. He thought that he would say something that would hurt his wife. He felt better when he heard that she would do her part in soliloquy. She apparently wanted him to know how she feels when he is unpleasant.

In the case of the A family* the inter-personal tensions and maladjustments between husband and wife were remedied by the psychiatrist, acting as an *intermediary* agent between them. Here, in the case of Robert and Mary, one acts as the auxiliary ego to the other. The psychiatrist is outside the situation acting as a preparatory agent before and as an analytical agent after the soliloquy is over.

The insistence not only upon the temporal but also upon the spatial *duplication* of the home scene is significant. On another occasion Robert said, "No, I could not go to bed here because our bedroom is located on the other side of the stage." A departure from his image of the structure of the original locality would break the illusion of doing it a second time.

Through the soliloquy technique the experience of the whole situation was far more clear than at the time of its occurrence. Man and wife here became acquainted with their inner selves in a most intimate way. Soliloquy provided a new psychological dimension for them.

Several times during the psychodrama we saw them stop. "No, it wasn't so,"—checking each other up, then continuing. Different perception of the same experience or distortion of memory often interfere with the effort of duplicating reality. The second partner opens up the possibility of checking on the accuracy of the first and determining how much of his material is fictitious. It rarely happens that both have spontaneously the desire for the same distortion of facts, but this has to be considered at times. The desire for fictitious substitution may be aroused by the staff members present during the psychodrama. The patient may have the desire to portray himself in a certain situation in a better or worse light than real-

ity justifies. He may want pity or admiration, or he may want to help the psychiatrist through acting in a manner which would please his theories. Here is a point where the cooperation of a life partner—his wife—is a valuable check against imagined trends.

The chief difficulties of Robert are well portrayed in this psychodrama. He lives in the permanent anxiety state of being late for an appointment. He portrays the anxiety he was in one morning before he came to Beacon Hill. The fear of being late pushes him forward. He hurries more than necessary, with the result that he often arrives far too early. The first time he came to Beacon Hill, he was two hours ahead of time. In another session he portrayed how he examined the alarm clock sixteen times to see whether it was properly set. It was first set at half past seven; he turned it back from seven thirty to seven, to six thirty, to six, worrying about the time needed to get out, he being punctual next day in Beacon Hill.

The *consequences* revealed that he feared incoming telephone calls which might throw his plan off, but when no one interrupted him from without he began to interfere with himself. He thought he had to go to have his shoes shined, to buy a tie, and to have his car looked over at the gas station. His problem is a "time" anxiety. In his anxiety he inflicts pain upon himself, and, if necessary, upon others. As he wants to use allotted time most efficiently, he wastes it. One integrated moment in the future—to be in Beacon Hill at 5:00 P. M.—extinguishes all the moments between now and then. He does not enter the moment in between. Indeed they torture him. But he said during the analytical discussion: "As soon as I arrived in Beacon Hill I was relieved and relaxed." He added that this time anxiety or time pressures interfere with all his functions.

Robert perspired lightly during the psychodrama. In the original situation which he described, the perspiration was more intense, he had headache and body tensions, he felt contraction of the facial muscles, pain around the heart and the need for frequent urination.

He rushed through the scenes in a comparatively short time. His wife could hardly follow him. He did, talked, and soliloquized far more than she during the same period. His behavior reflects that in the corresponding life situation he had been crowded, at the same time, with too many intentions to act. In consequence he tried to crowd a certain duration of time with too many acts. As soon as his anxiety that he might not be able to accomplish what he anticipated began to act upon his mind, the rush into time came to a stop or even to a regression, with the result that he was continuously crowded with unfinished acts. He feared to start anything new. Sometimes a task that would take but one minute remained undone. It is

significant to note that he enumerated in soliloquy the different acts he planned to carry out in the order of their succession. Every act has its anticipated position in the time-continuum, and woe to him if he does not comply with it. His sense for the duration of performing a certain immediate task becomes neurotic, and this compels him to become neurotic in respect to a far end of his time scale—for instance, that he will have to be in Beacon Hill at 5 00 P. M. three days hence. This reduces for him the spontaneous flow of acts in duration to an extremely rigid line—an inflexible pre-established order of successive acts. The psycho-pathology of his time function explains also how spontaneous states become overheated. A spontaneous state, to obtain full expression, has to be free from being crowded, from new acts rushing simultaneously into the act already going on. In the discussion the patient said that he feels driven to be on time regardless who the person is whom he is to meet. He claims that it makes little difference whether the other person is prompt or not. It is not the result of outside pressure, but a standard within himself, a moral standard. But in fact this condition reflects upon his inter-personal relationships. Soon after the situation above had been psychodramatized, three of the other guests had to leave to reach a train. He was tense and perspired. He admitted that he was in an anxiety state, he feared that "they may not reach the train on time." He was inclined to want his time-complex not only for himself but as a universal standard. As he is ahead of time, he tortures others who are intimate with him (his wife) if they don't keep pace with him, and he tortures himself if he doesn't keep pace with the clock.

In the psychodrama he showed another peculiarity, the desire to have things in "the right place." He censured his wife on this point. Once he confessed that when he came to see me for the first time he felt uncomfortable because a corner of the rug was turned. A piece of paper, a nail which seemed to be out of place irritated him. The rigidity of the time line had a counterpart in the rigidity of arrangement in the spatial manifold. Time neurosis and space neurosis in this case went together. It may be the rule. However, the patient claimed in the discussion that he was "more concerned about things being on time than about things being in their place." He wanted a pre-established order in time and in space. He did not wish to be taken by surprise. The ideal order would allow him to run his life with the least resistance.

During a combined analysis of the portrayals he gave of his father and mother and of his soliloquy, he said, "My father is always rushing like I am, and I am much like my mother, too." Then he added abruptly, "That I find everything out of place, this I have from my mother. That

"I wish and feel myself out of time that I have from my father." Obviously he tried to adjust his father and his mother in an original way in making the outstanding peculiarity of each a part of his own ego, to prove that they do not have to separate, that they can live in harmony within him. But he in turn became neurotic.

PSYCHODRAMA 'ON THE SPOT' AS SELF THERAPY

An important question was raised by the patient's wife. How should the act in situation look like the one above? At times the patient found relief in psychodramatizing, in his itself a process of action which he couldn't face if he, without the room, he had received in Beacon Hill. In general, it is only valid to let the patient psychodramatize and soliloquize, hit or miss, all thought and feelings into the midst of a life situation. Psychodramatic and soliloquy should be restricted as much as possible to the therapeutic theatre. The theatre is an *objective* setting where this extremely *subjective* process can be carried out under guidance. Psychodramatic technique may however be projected to the patient gradually in life itself, in *key* situations, it can be applied by the patient himself or one of his life partners. This eventually becomes a very important therapeutic extension of psychodramatic work.

Robert was in a deep anxiety state one day. He was aroused by a call from the store across the street. He had already prearranged the tasks which he had to finish during the day and he did not see how he could also take care of the store job. On the other hand he did not want to disappoint an important new client. He worried as to how he could squeeze it in between other things. But for more than two hours he stopped doing anything. In trying to figure out how he could do the store job, he did not do the other thing either. Under ordinary circumstances he would have wasted the whole day, but reminded of the work with us he tried to warm up and to face the situation directly. He ran across to the store, talked with the man in charge. He was told that he could do the work just as well another day. When he heard this he relaxed and went back to his office.

A few days later he had an unpleasant scene with his wife. I suggested that he dramatize what has happened on the stage.

Situation: Robert and Mary on the way home after a party set in the car on his side of the car. At the party he had been violently critical towards everything his wife had said in a debate.

PROCESS

Gestures and movements

Robert and Mary sit in an improvised automobile on the stage

Dialogue

Robert explains to the director. This was the first time that I took the initiative in applying psychoanalytic principles outside of the therapeutic theatre. If I would have delayed in my usual manner, our relations would have been tense and unpleasant for days and no one would never have known why. But I stirred myself up and acted --

Robert: Do you know why I was angry during the debate and why I was mad until now?

MARY (anxiously): I don't know why.

Robert: Because during the debate when I talked to you, you never looked, listened or answered me, but you looked flustered and answered everybody else who was present. But I am not angry now. I realize that you talk with me every day. It is often a pleasure to exchange opinions with a different person.

MARY: But I am still angry, not only because of me, but what will these people think of you?

Under ordinary circumstances if Mary were angry, Robert would rapidly have fallen back into being angry again, but they continued to enact the experiences which went back and forth between them during the debate until they both relaxed and their anger vanished.

Another time the therapeutic action came from his wife.

Situation: When Robert got up in the morning, though he looked calm and serene, he was full of anxiety about doing certain things on time. Under the usual circumstances Mary would not have let Robert know that she felt what was going on in him behind the smooth exterior.

PROCESS

Gestures and movements

Robert telephones his office and speaks to his secretary

Dialogue

MARY (quietly): When do you have your first appointment?

Robert: At one o'clock.

MARY: Then you have four hours' time to rest. Couldn't you call your secretary? She can let you know if an emergency arises.

Robert: That's an excellent idea.

Mary explains to the director that this scene was the starting point for an exchange of experiences in regard to what had happened to Robert when he awakened. Finally he calmed down.

PSYCHODRAMATIC TECHNIQUE OF DREAM PRESENTATION

Robert and Mary often had dreams about each other. They were a new challenge to the imagination of the psychodramatist.

The dramatization of a dream places the subject in the position of the sleeper, so that he can warm up to the state of dreaming on the stage. The dreamer actor portrays his dream on the stage, warming up to the act of dreaming instead of telling the dream. The total psychodramatic situation of the dreamer is portrayed in such a fashion that every bodily action of the subject, the relationship to objects, persons, and to the total environment, becomes visual. The dream-characters are like wax figures on the stage; they move, sit or spring to life as the dreamer directs them.

Situation. Robert enacts a dream which he had the night before in Beacon Hill. The patient is prepared by a member of the staff. He is told to sublimize the dream in movements and in words.

PROCESS

Enter the movements
The patient is on the balcony of the theatre.

Walks from the balcony down to the road stage.

He walks around in circles.

An actress, e.g., portrayed Paul. Another actress portrayed Paul's older brother.

Patient walks down the steps.

Soliloquy

This is a room I am alone. *There is a four poster bed in it.* Someone called me downstairs.

I went down a flight of stairs. *It was a straight flight of stairs.* When I got to the bottom, I came into a restaurant. I went through the front door into the street. I didn't have my overcoat or hat on. I walked to a bright store. It was a hardware and souvenir store. I saw three people who had lived in the same tenement house with me in New York City about sixteen or seventeen years ago. I noticed Paul sitting upon a high stool which had no back, and I walked over and said to him, "Hello, you must be Paul." I saw one of the older brothers. I heard him give a cough. I said to myself, "Why that must be the brother who has tuberculosis of the throat." And then the dream ended.

Dr. Moreno had told me the Sunday before that in the event I had any dreams, I should try to recall them and mark them down. Then, while I was still dreaming, I said to myself, "Dr. Moreno said that I should mark my dreams down. I had better recall this dream so that I can mark it down." I started to record it and said, "Let's see. *First I was up in the room, and then I started down the stairs, and then I awoke,* and that was the end of the dream."

ANALYSIS

The patient's actions on the stage recalled in me the poetic dramatization of dreams as in Calderon de la Barca's play, "*La Vida es Sueño*" (Life is a Dream). But in the psychodrama of dreams the dreamer is his own playwright and his own actor. He has to reach by means of auto-suggestion, a near-dream state, a posture of the body and a level of feeling which may help him to duplicate the dream hallucinations. A couch on the stage can be used for this preparatory phase before the action begins. The patient had recorded the dream after waking up and verbally presented its content to me several times. Certain portions of it, however, come to his mind spontaneously as he acted on the stage. The first thing which he added during the portrayal was the *four-poster bed* in the room. Then as he moved down from the balcony on the stage he realized that it was a *straight stairway*, and not broken up as on our stage. It appears that the process of warming up to his role of a dreamer and the projection of his movements upon the stage may at times release emotional tensions which are not so easily remembered in retelling or in simple word association. Finally as he walked down the steps of the stage he soliloquized the *true* end of the dream. The dreamer recapitulated the course of the dream to himself: 'Let's see. First I was up in the room, and then I started down the stairs.'

The dream has two parts—a true dream and an inter-personal portion. He awakened during the dream, which marked the end of the true dream. The additional piece is like a soliloquy in a psychodrama. The patient stops the act for a moment and takes a look at himself and a look at me and explains how his anxiety that he may forget this dream induced him to *rehearse* it although still dreaming.

The process of starting, especially the use of bodily starters, in the warming up process, brings up the question of how reliable free word-association may be as a guide to the deeper levels of the psyche. We have seen that the position and the role the patient is in when the words emerge determine largely the *kind* of associations he will produce. The words and phrases he utters while lying on a couch in a passive state, and the words and phrases uttered when he moves his body up and down are *not* the same. And if there is another person, for instance, a physician whom he likes or dislikes, in the room when he associates the words and phrases, they are again greatly changed. If the other person present is in the role of his sweetheart, his father, his employer, or a mass of people, the pattern of associations is again different. Still more radical changes take place if he is not in the role of a patient but in the role of a brother, a lover, or a friend.

TECHNIQUE OF SPONTANEOUS IMPROVISATION

Spontaneous improvisation is a technique in which the patient does not report events from his own life, but acts in fictitious, imagined roles (5). Here, in auxiliary ego has a double function. On the one hand as a starter to get the patient working in a particular role, on the other as a participant actor in a role which the situation demands. The patient warms up to various roles which he may have wished to represent in life but which had been frustrated. He acts opposite various people in symbols and roles which are either pleasurable or painful to him. These people in different roles project their own personality at him. The procedure becomes a significant test of the patient's behavior in his various inter-personal relationships however much he may try to avoid it. Many elements of his private personality enter continuously into his fictitious roles. They offer an open target for analysis.

Situation. Robert and Mary, his wife, the principal characters. The patient and his partner are prepared by a member of the staff. They are told not to portray themselves but to improvise spontaneously roles which are suggested to them. The role suggested to the patient is that of a sheriff. The role suggested to his wife is that of a shoplifter who has just been brought before the sheriff.

PROCESS

Get into role and movement
Off stage

The patient gets up and turns half towards his wife and half towards the psychiatrist, apparently uninvolved.

His wife remains seated, equally uninvolved. Both are unable to warm up to the characters. A member of the staff aware of their behavior, steps in.

Dialogue

ROBERT: Come, let's start
MARY: All right

I think that it would be better for Ann to act as the shoplifter instead of Mary.

Robert and Ann, another guest at Beacon Hill, run up the stage and give a vivid characterization of a sheriff and shoplifter. Both warm up easily, click immediately. The dialogue flows in easy rhythm.

In a later session the following day the patient and his wife are again asked to portray the situation together, sheriff vs. shoplifter. She urges him, and this time they actually try. The essence of the portrayal, however, is that they do not warm up well. The dialogue is not convincing. She does not act like a shoplifter but like herself, and he does not act like a sheriff, but like her husband.

Situation "Third Degree" Robert, the district attorney Ann, a gangstress He puts her through the "third degree" Both warm up easily and give a convincing portrayal.

Situation Robert as Mephistopheles in Hell Several persons asking admission The patient enjoys his acting

ANALYSIS

In spontaneous improvisation, the task is in one respect the reverse of that in self-presentation Here the subject tries to *prevent* his private character from interfering and from mixing with the fictitious character. The struggle, competition, and eventual collaboration of the two, the private and the fictitious character, is visible in every portrayal The ambiguity of presentation is full of clues for the study of a person Two of the factors producing the ambiguity of a role are the private feeling of a patient for his partner, and the desire to dominate the situation and to develop not only his role but also the role of his partner This latter mechanism produces at times a private struggle between the two partners, an ambiguity in their relationship which interferes with the roles to be presented and sometimes shapes them into a pattern which contrasts greatly with the original intention Another factor is the private feeling of the subject for the persons watching the performance in the audience The most important analytical task in this procedure is to separate carefully, as far as possible, between the private ego-material projected into the character of the role and the fictitious content of the role itself

The patient discloses selective affinity for roles which place him in a position to torture others Sheriff, District Attorney, and Satan are professional sadists The therapeutic theatre gives him an artistic excuse to let himself go and perhaps the enjoyment he has in performing them and the completion of detail with which he carries them through in gestures and words, indicate the role he would like to play in life had not the pressure from without and within compelled him to reduce his sadistic trend to a neurotic sketch He was twice negative in the portrayal of the Sheriff, with his wife acting as shoplifter, but extremely positive when acting with Ann in the same role He selected Ann as partner for the role of a thief As the analysis revealed, he did not choose her because he imagined her to be that type of woman, but because he felt that she was able to embody this role effectively *1 role in one person may have a tele relation to a certain role in another, although they may be indifferent to one another as private individuals* This may indicate that the patient did not want his wife to portray a vulgar and disreputable character perhaps be-

cause of the fear that she might betray some of her private ego material to him and to the people present. He may not have wanted to act in a role towards his wife which demanded cruelty and brutality, perhaps because of the instinctive fear that he may do that in excess. On the other hand, all this declares the importance of clicking in the warming-up process to role-relations between two persons. Robert and Ann appeared convincing in the Sheriff, the District Attorney and the Hell scenes, but they failed in a love scene together. The interpersonal clicking in respect to certain roles does not imply that they would click as easily in other roles or as private persons. The fact that individuals click well in some roles, less well in others, and that in one role they antagonize each other, explains the complexity of telerelationships. These come to the fore the more intimate and thorough the contact between the two persons is, as between husband and wife, parent and child. The tele between the same two persons can in numerous respects be positive, in numerous respects negative, and in numerous respects show varying degrees of positivity. The tele-relationship has to be analyzed from both persons' viewpoints simultaneously. The tele-relationship is not positive if one person is able to warm up but the other person is negative in return. The complexity of configuration of tele-relationships increases the more numerous the persons are who take part in a situation, and the more varied the roles in which the individuals act or desire to act, and finally the more varied the criteria of the groups in which they participate. This is one of the points which forced early spontaneity work into sociometric study. When numerous persons acted in the development of a psychodrama, a certain person, A, was not only influenced by his face-to-face partner, B, but also by C, D, and E with whom he had not acted face-to-face. They had acted, however, face-to-face with and influenced B who in turn influenced the part of A. We had then to distinguish between the tele functioning in the presence of two partners, and the tele which works by induction, a distant tele effect. This observation paved the way for my sociometric studies.*

Third Degree,¹ a situation in which the patient and Ann acted as district attorney and gangstress, respectively, disclosed many points. For a few minutes Robert was fully absorbed in his role and Ann in hers. He

*Study of a resettlement community near Vienna, 1915-17.

Salem Prison, Ossining, New York, 1931.

Brooklyn Public School 181, Brooklyn, New York, 1932.

New York State Training School for Girls, Hudson, New York, 1932-1937.

Riverdale Country School, Riverdale, New York, 1932-1933.

Also see references 3, 4, 5.

tried to get her to confess a hold-up and she used her wits not to betray anything. From a certain point on, a private element entered from both sides into the picture. It was not only a fight between a district attorney and a criminal, but aside from this, a contest of two wills. Each persisted stubbornly in a point taken, more interested in themselves than in the form and value of the plot. This feeling colored all their gestures, arguments and words. It influenced the creative process itself. They were 'in' their roles for about ten minutes. For the next ten or fifteen minutes they were merely "acting" in these roles. Each was trying to master the other. The conflict between the four roles, two roles portrayed by each person, can be explained as follows: a person rushes into a role and warms up adequately to the spontaneous state demanded by it. He is entirely absorbed by the role he acts. It is typical that afterward he remembers hardly anything of the phrases he actually spoke and the gestures he actually made unless in the effort to reproduce he falls back into the same spontaneous state. To both Robert and Ann in the roles of the District Attorney and the criminal respectively this sort of thing happened. Up to a certain point they stimulated one another until each developed a different idea of how to continue the situation. As neither had sufficient spontaneity to carry the other, the situation came to a deadlock. In this moment of mutual calamity each brought to their rescue their private roles. Robert came out as Robert and Ann as Ann. The District Attorney and the criminal woman were for a moment enveloped and distorted by the way Robert felt about Ann and Ann felt about Robert. Latent personal jealousies suddenly had an opportunity to express themselves. The dilemma was increased to heightened tension and the director had to interfere.

When a person is entirely absorbed by a role, no part of his ego is free to watch it, and so to record it in his memory (6). He is as if in a dream. Even the functioning of his memory becomes involved in the task of developing the role. I have suggested many times to individuals who had a great selective affinity for a certain role and also for the partners with whom they worked to try to register as he went on as much as possible of the inner and outer events. The experiment had the following results: the more he tried to act and to watch himself at the same time, the more he was in danger of failing in his role. His effort was then broken up in two parts, the part which he did for me, to remember, and the part he acted in the plot. This may explain also the configuration of Robert's dream as a spontaneous effort. It is not *one* dream, but it consists of two parts, each with a different meaning. He rarely remembers the details of his acts. But upon my suggestion, he tried to remember the dream. This trying to remember is an

interpersonal process, a play between myself and the patient, or better said between myself and that *part* of the patient's ego which he has reserved for psychodrama.

Now let us return to the same mechanism in spontaneous improvisation. *The key observed on individual is in his role, the weaker the spontaneous state, the more is that part of his ego which watches the performance able to disturb and to disintegrate the procedure.* The individual performer has therefore to be careful not to let the desire for remembering interfere too much with the realization of the act.

The function of training the ego to do a double task, to think and act simultaneously is, however, within practical possibilities. I have seen numerous cases in which a subject had learned how to act a role and to register its content at the same time. However, this private part of the ego, when it becomes too active within spontaneous improvisation is responsible for numerous interpersonal disturbances. If the spontaneous state into which the subject throws himself is full and strong, it matters little. Even then he may develop an anxiety state, the anxiety of losing his presence in the role and towards the partner. The anxiety state increases in gravity if the performer has had a weak spontaneity state from the start, and if his *will* to carry it for a sufficient length of time is limited. The feeling that one's spontaneity state is weak may discourage the subject from the start and urge him to stop after a short run.

The feeling that the duration of a state is limited can produce a conflict which we have described as developing between Robert and Ann in 'Third Degree'. Both started with a strong and full state but as they came closer and closer to the end of the time permitted them, they became irritated. At last the spontaneity state began to wear out, to fade, so to speak. Each one's private ego came in, the *will* to carry on entered into the fray. It became a contest of their characters. The fading out process of the spontaneity state became evident on both sides in repetition of phrases, repetition of movements, and besides, the spontaneous state was artificially carried far beyond its natural duration.

THE WARMING UP PROCESS IN THE SEXUAL ACT

Valuable observations have been made in all emotional states in which two persons are interrelated in one common activity. In the sexual act, for instance, the mechanisms of starting and finishing the preparatory phases reveal similar inter-personal dynamics. The sexual attitude may develop too weakly in one partner or the other. It may have a more limited duration for one of the partners than for the other. It may fade out in one

or the other ahead of the psychological moment. If for the above reasons the psychological moments in both persons do not click, anxiety states are the result. These anxiety states are reflected on the momentary structure of the inter-personal situation. These configurations, the way in which one point in the warming up of one person corresponds to the warming up of another person, can be studied objectively and with great accuracy in spontaneity work.

Love partners have occasionally portrayed the development of their relation on the stage. It is of advantage to look at the sexual act as a psychodramatic situation in which two actors are engaged. The two actors may differ in the speed of warming up before and during the act. They may be guided by conflicting perceptions of what is appropriate or inappropriate behavior. The warming up process in the sexual act is accompanied by auxiliary images, especially visual, auditory and motoric. The images conform at times to the state of sexual performance, an increase of pleasant visual images when the sexual act moves rhythmically and smoothly, an increase of motoric images when the motoric aspect of the sexual act increases in intensity. When however, the performance is not adequate and the warming up process is lagging, auxiliary images of every category emerge in the sexual actor as if trying to come to his rescue. The images express often panic, pain, visual and tactile patterns of previous experiences. Their incongruity with the actual situation may produce the opposite effect, a sexual act divided, a separation of the two lovers from the common aim and an unsuccessful finish. Many cases of sexual impotency are due to prematurely emerging auxiliary images of an awkward type, a lack of strong and adequate images at the opportune moment, or an abundance of uncomfortable images in a crisis. A helpful method of retraining the sexual actors has been found in a technique of therapeutic images. They are encouraged to develop images appropriate to the inter-sexual situation as a stimulus to the warming up process. A similar technique has been discussed elsewhere as an aid in the spontaneity training of creative artists.*

TECHNIQUE OF SOLILOQUY--SECOND TYPE

In the first type of soliloquy the asides and the dialogue operate within the private world of the subject. They are in different dimensions but they belong to the same person. They belong to the same scene which they both portray. The "open" part re-enacts the bodily and mental processes which

*See "Psychodramatic Treatment of Performance Neurosis," Psychodrama Monograph No. 2, Beacon House, N. Y., 1944.

had actually occurred in the original situation. The soliloquy part enacts the bodily and mental processes of the person at that time which he did not reveal to his partner. It is an enlargement of the self through a psychodramatic technique, and these secret mental processes flow to the person to whom they should have been communicated originally. It is here that the therapeutic effect comes in.

A second type of soliloquy has been invented in which the official act and the soliloquy are on different levels. The official act portrays a fictitious role in a fictitious situation, for instance, God in Heaven or Mephistopheles in Hell. The soliloquy act in the psychodrama will differ from the private asides in the legitimate theatre. In the psychodrama both warming up processes are *spontaneous*; the role taken and the private immundos. In the legitimate theatre the role taken are rehearsed, only the private asides are added. The soliloquy acts in psychodrama are private reactions of the patient and his partner. They portray the unspoken, private feelings they may have in regard to themselves, to each other in their roles, to the task they are trying to produce or to persons in the audience. Imagine John Barrymore and Eva La Gallienne acting on the legitimate stage in the roles of Shakespeare's Romeo and Juliette, and imagine too that Barrymore and La Gallienne are permitted to say in asides how they feel privately about one another. *These soliloquies are not enlargements but resistances to a full development of the role.* It is here, therefore, that a therapeutic approach comes in.

Situation: The scene is in an office of a home relief bureau. The receiving officer is Robert. The client is Mary, portraying the character of a widow who has applied for relief.

PROCESS

Entrance and movement

MARY enters into the room with definite and quick movements, dressed for her role. She carries the state through to the climax up to one point where she soliloquizes, makes a comment about her husband. Robert is distant from this start. The expression of the body is "and oh!"

He is passive in his dialogue. He has no keen insights but no comments. All the loud comes from Mary.

Dialogue

Soliloquy

MARY—What do you mean no more people are permitted in I'll get in. Oh, you're Mr. Newman, aren't you?

Gestures and movements

Dialogue

Stage business

ROBERT--Yes I'm Mr Newman. How did you get in here today? No people are supposed to get in here today. We are too busy today.

MARY--Too busy? What do you care. We have no food and we are going to lose our home today. For two weeks you've been making promises. You would send an investigator. But you haven't sent anybody around.

ROBERT--I'm sorry but you will have to wait until the investigator comes. That's all there is to it. We can't take care of each individual case as it comes in here.

ROBERT--Darling, this is really getting bad. I can't get warmed up to this role. I don't know why.

MARY--I've been patient long enough. I've been waiting. I have no food. The neighbors have been supporting me. They can't help me. They're poor people too.

ROBERT--I'm sorry but I can't take care of each case that comes in here now. I've got a lot of things to do today and I can't listen to you anymore. That's all. Get out of here. That's all I can say to you.

MARY--You'd never talk that way to a child. You'd never get away with it. What you need is one year of work in a relief bureau. It would make a better business-man out of you.

ROBERT--No ideas come to my mind. Hell, she is better than I am.

MARY--I'm not going to move from here until you get me a food ticket. My children are hungry. I've got to have food for them. I've showed you my dispossession. What did you do about it? Nothing. You sent me to court. What did they do? They gave me five more days and my time is up tomorrow and I'll be out on the street. I want a food

SOLILLOQUY AND MONOLOGUE

Dialogue

Soliloquy

ticket and I want the investigator to come tomorrow and speak to me, Sanford.

ROBERT: O. K. if you get put out on the street. Why don't you go out and get yourself a job instead of coming around here seeking relief.

I don't care whether you get put out on the street at all. As far as I am concerned I don't care a darn. That's all there is to it. Now, get out of here and out of here.

MARY: Get a job? Who will take care of my three children? They have no father to take care of them. That's why I'm here. For a whole year I struggled on the insurance money he left. I waited until the last minute. This is what I get for waiting and being honest.

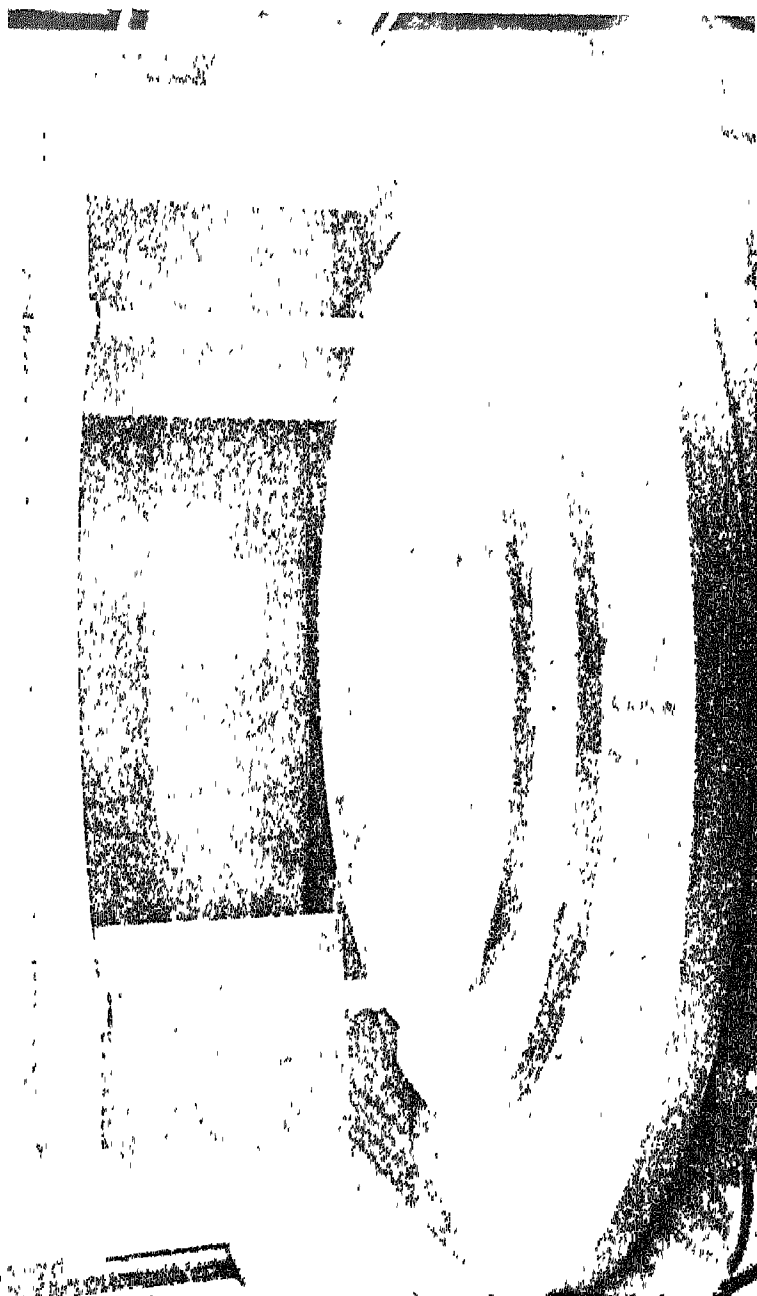
ROBERT — The doctor is watching me. He thinks Mary is better than I am.

ROBERT—She is very well warmed up to the role, and I didn't think we were so well warmed up.

ROBERT: I don't care who take care of your three children. They can take care of themselves and so can you. Why don't you go out and get yourself a job?

ANALYSIS

Robert soliloquized several times. Mary only once. Mary was better warmed up to the role. Robert fell out of it again and again. It was in these phases that he soliloquized. *A spontaneous subject who is entirely absorbed in the role is unable to soliloquize either in regard to himself or in regard to the role. It is with that part of his ego which is not swept into it, hypnotized by the role, that he can soliloquize.* (6) The weaker the role absorption by the ego, the more often can the ego soliloquize. If the ego cannot warm up to it at all, then we shall find the subject on the stage soliloquizing, making excuses for not getting into it, or suggesting different roles for himself. Robert and Mary soliloquized in several ways. They soliloquized in regard to the roles they were in, reactions which sprang up in their minds



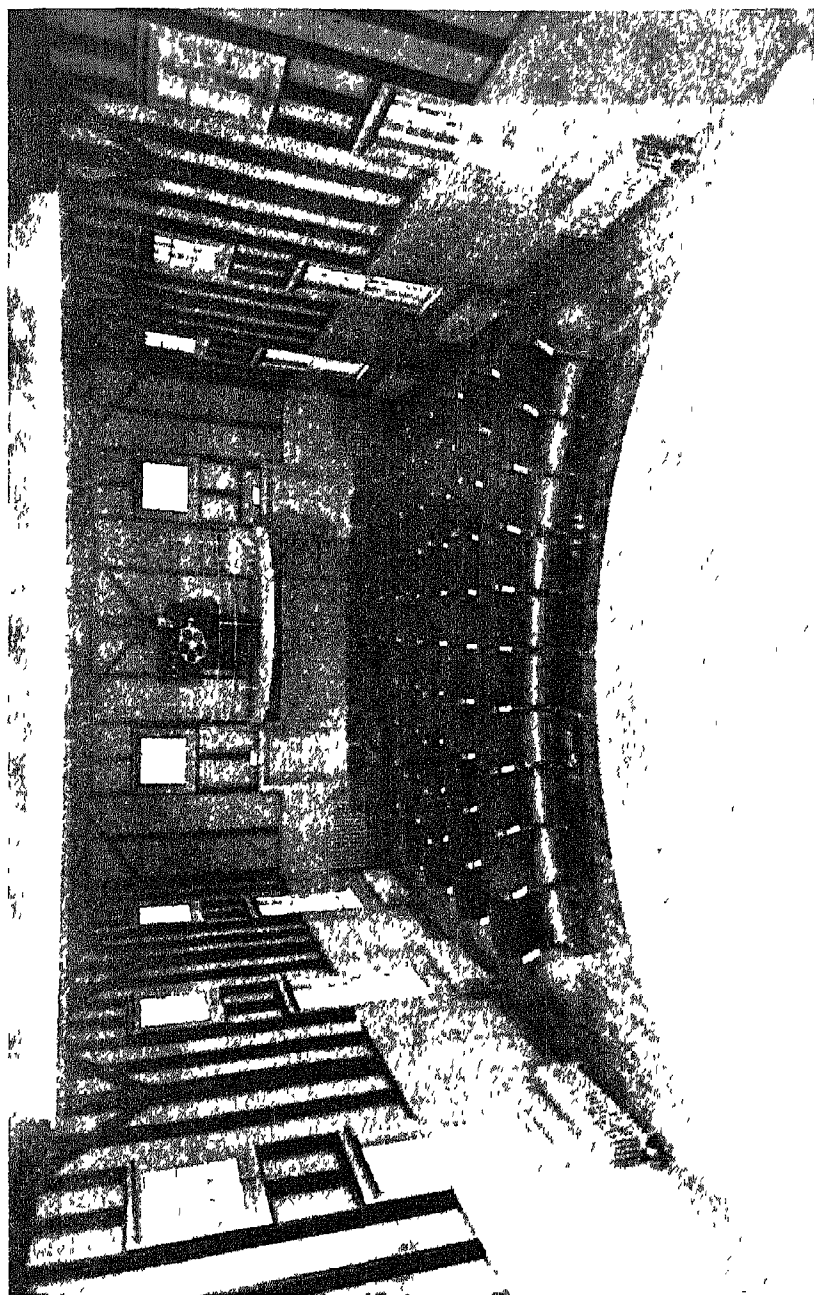


Fig. 1. Author's view of the structure of the pipe, showing the grid-like pattern on the left side.

in regard to their private persons, and their reactions in regard to each other. She drove and led, he was weak, repeating the same phrases often.

The frequency of soliloquy is here a test of the intensity of the role. The more often the role is interrupted, the weaker will be its unity. Many times we see the patient breaking up the flow of associations. Face and body are then out of the expression which the role demands. We see this whether he soliloquizes or not. We see from the tests that the closer these interruptions are to the end of the state, the harder it is for the patient to throw himself back into it. A start of the state sufficiently intense protects the patient against the effect which interruptions may have upon his performance. The interruptions can come either from within himself or from his partner in the act. We call these interruptions *resistances*.* They can be introduced by the psychiatrist at will into the course of action so as to train the patient not to fall out of the state while acting, whenever resistances emerge spontaneously either from within himself or from a partner.

The point of therapy is here not as much analysis of one or the other independently, but a careful analysis of their inter-relationships with a special study of every fundamental "role" in which they act as partners. Parallel with the inter-personal analysis of the roles in which they act should go a methodical preparation of the roles they need to act in the course of their "training." Indeed it cannot be done otherwise as the analysis is fruitful only as the training proceeds. *The technique of improvisation is the royal route of spontaneity training as it throws the patient into roles, situations and worlds in which he has never lived before and in which he has instantly to produce a new role to meet the novel environment.* More than therapy is provided. It is training and development of a new personality which may differ greatly from the one which was brought for treatment.

THE THERAPEUTIC PROCESS

The intermediary technique† of the auxiliary ego in life situations is replaced by psychodrama. Partners in a conflict find in this procedure a more objective setting for treatment. Therapeutic tele flowed through a chain of five persons, man, wife, the psychiatrist and two assistants. The time and space neurosis had been fully developed before he met his wife, but it affected and shaped their relationship and produced a secondary condition, an inter-personal neurosis, overlapping the first. The treatment of the secondary condition was used as a lead for the treatment of the first. The wife was used as a therapeutic agent, at times taking the place of the

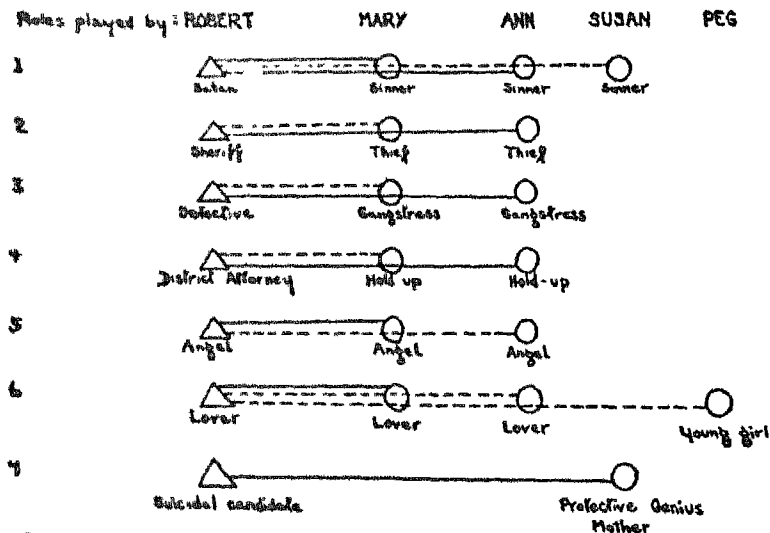
*Do not confuse with the psychoanalytic use of the word

PSYCHODRAMA

psychiatrist in regard to the patient. The patient himself was used as a therapeutic agent at times, taking the place of the psychiatrist in regard to his wife. The therapeutic situation is the process occurring on the stage. The relationship to the psychiatrist is auxiliary. In the treatment of family A* the psychiatrist was in a key position, as the auxiliary ego for each of the three partners independently, and at times simultaneously. In the case of Robert and Mary, the partners are acting face to face.

The function of the auxiliary ego is further modified. Instead of being a carrier of mental news from one to another he is now quietly preparing the ground for the decisive event—the psychodramatic interaction between the partners. The thinking, recording, and analyzing of each by the other is carried out

CHART I



Diagrams of the interaction of people and roles in the case of Robert and Mary in the seven different situations depicted. Robert appears variously with Mary, Ann, Susan and Peg. The roles played by each of the five are represented in the columns directly below their names. The differences in satisfactoriness, with which the situations were developed are represented by the lines between the characters: the solid line represents a positive response, a good development of the roles; the broken line represents a negative response, an unsatisfactory development of the roles. In situation 1, Robert as sinner had a positive workout of the role when the Sinner was portrayed by either Mary or Ann but a negative workout with Susan as Sinner; in situation 4, Robert had a positive workout on the role of District Attorney with Ann as the Hold-up girl, but a negative workout with Mary in that role. These diagrams make clear the way an individual can respond differently to different individuals, and how a person's response to another person can change as situations are altered.

INTER-PERSONAL RELATIONS

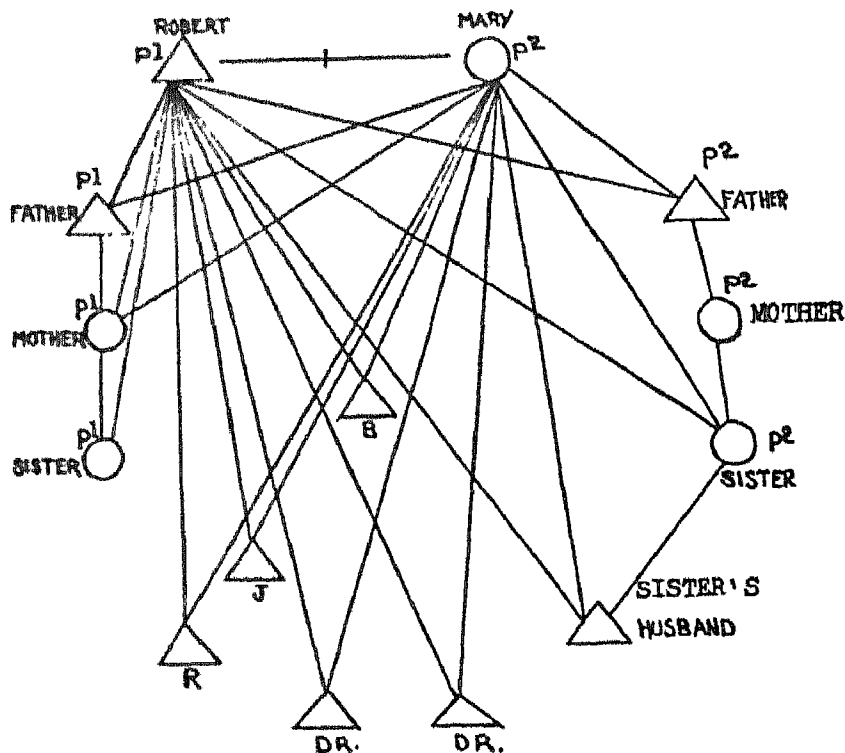
by the actors themselves. The persons who fostered and shaped the mental disease have become the main agents in its cure. But the psychodrama operation takes place in the presence of the psychiatrist and his staff, this determines his function as an auxiliary ego. On the one hand, the psychiatrist arouses and starts them, prepares them for the key situations to be portrayed, on the other hand, he leads their analysis after the scene and tries to arouse and stimulate them to spontaneous reactions during the analysis. During one scene Robert acted and his wife watched him, sympathizing or often violently disagreeing with him. At other times she acted and he watched her. After a psychodrama had been finished they brought out important information in the course of inter-personal analysis. They added parts which one or the other had left out in a scene. Perhaps the most important of these after-revelations was the wife's criticism that the patient persistently left out scenes which had happened during the week. He enjoyed presenting his space and time complex. He put it on *exhibit* repeatedly and with so much emphasis that other parts of his conduct, for instance, his sexual situation, which should have deserved at least as much attention and portrayal were neglected. At times what seemed important to him did not seem important to her. In consequence they placed emphasis on different points. The therapeutic urge of the wife appeared at times stronger than his. This became an extremely important stimulus in the treatment, for instance, the insistence on portraying sexual situations came from the wife, it did not come from an outsider (the psychiatrist) but from an insider in the conflict. This experience brought about a change in the technique of preparation. Instead of asking only him for a report of the most crucial situations during the week, we began also to ask her. The leads from both sources were then used in the construction of treatment situations.

In the case of Robert, the tele for numerous persons was studied to determine the one which promised to have the greatest therapeutic potentiality. His wife, notwithstanding their inter-personal difficulties, appeared as a good agent. This is not surprising as the attraction to one another was mutual and spontaneous. Yet there was antipathy also. It had taken them about seven years of courtship to reach the conclusion of marriage. Indeed their negative tele for one another in regard to this or that phase of their behavior proved to disclose valuable information concerning their inter-personal dynamics, information which neither of them might have communicated if treated independently.

Some patients are inclined to talk excessively about what happened to them during the treatment and to apply what they have learned uncritically to others. If two patients are treated together as in the case of Robert and

Mary on a long and convoluted series. They may continue to psychodramatize their relationship and to sidlequeer perpetually in the home and wherever they go. To avoid mutual excitation and irritation the patients are advised to consider the treatment in the theatre as the objective setting in which their inner emotional conflicts are handled. During the first weeks they are advised to discuss their experiences in the theatre as little as possible, and

CHART II



Robert's psychodramatic history may have a wide range. The twelve persons above mentioned and Mary appeared at one time or another in their psychodramatic scenes, and the analysis went largely following them. These people compose the major part of the constellation of the patient. The chart is incomplete in that the quality of the relationships is not indicated.

secondly, to apply psychodramatic techniques outside only under guidance. Under proper guidance this can produce an excellent therapeutic effect.

Another aspect of the therapeutic process in the case of Robert is *the relationship between pushing an act and relaxation*. Robert, however, he

may be rushed feels relaxed as soon as he has arrived at the place of destination, as soon as he is in my office, as soon as he has talked with the party whom he had tried to get on the telephone, as soon as he has ended a scene in the therapeutic theatre. Common to all these situations is a warming up to a spontaneous state which as soon as it ends turns into an anticlimax, relaxation and pause. It is a spontaneous state in which the person wishes to be interrupted as little as possible and which moves rapidly towards an end.

In social situations numerous persons or events may interfere with the finishing of a task. The individual has to learn to be flexible enough to hold the spontaneity state in suspense until the interfering factor has disappeared, or be able to throw himself back into the situation. In the psychodrama, Robert found a field of action which is, from at least one point of view, preferable to the solving of problems in life, namely that the number of interferences and resistances in time and space are so few that they can be almost neglected. It is a dream-land in which painful tasks in life are finished by the gesture of a hand or by a smile. Scenes in life which endure for days are here reduced to a minute. One can move toward the end of a scene with comparative ease.

This is one reason why one feels so relaxed after psychodramatic work. Evidently the relaxation and the pleasure the patient derives from the acts come to him more easily and more quickly than in the acts in life. This is also the reason why he feels most relaxed after situations in which he has acted in a dominant role, in which he has an opportunity throughout the psychodrama to be the only standard in regard to time, space, direction, dialogue, and the moment of finishing. The others have to adjust to him: to the duration of *his* state, to the change from one state to another as it pleases *him*, to *his* movement in space, to *his* change in position, to *his* turns in the dialogue, and the moment when *he* feels it desirable to end, which he chooses solely to his own self-aggrandizement.

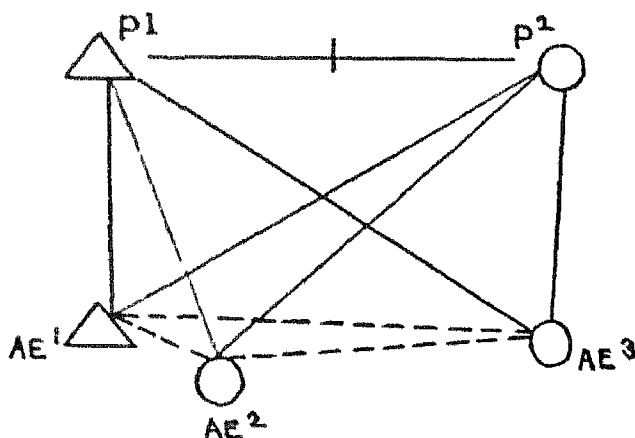
The resistance* which we describe here is not the one within the patient. It is *between* the patient and the partner or partners, it is an *inter-personal resistance*. A therapeutic measure in the case of Robert was therefore the *interpolation* of resistances. Objects, events, persons were carefully put in the way of his unlimited self-expression and self-exhibition. We have seen that he was better than the average in attempts at uninterrupted self-expression but that he often made a comparatively poor showing in contests when another aggressive ego was put as a resistance into the course of his action.

*See discussion of concept of resistance on pp 35 and 44

The resistance had to be *granted* carefully. In this form of simple spontaneity work, a maximum of resistance can be invented to meet the needs of the patient.

In the case of Robert and Mary, the dynamic distribution of therapeutic tele had its greatest intensity between the partners themselves. It was apparently second in intensity between the psychiatrist and the two partners. It was third in intensity between the two partners and my collaborators. The aim of the treatment is to develop therapeutic tele in relation

CHART III
RELATION OF THE THERAPIST TO THEM



P1 - Man
P2 - Wife

AE1 - Auxiliary Ego
AE2 - Auxiliary Ego
AE3 - Auxiliary Ego

The straight lines indicate the direction through which the therapeutic tele flows. The arrows indicate the direction between P1, P2, and AE1. The dotted lines indicate the relation between the staff members who are active in the treatment. These relations have therapeutic importance.

to as many individuals who belong to the social atom of the patient as possible; in other words, to develop all individuals who are in contact with the patient and who are in a natural tele relationship with him by attraction or repulsion into agents of therapeutic tele. In the case of Robert only one member of his normal social atom, the wife, is included in the treatment. Other persons who live separated from their present life-scene, their fathers, mothers, relatives, and friends are not included. Auxiliary staff members participated in as many roles as necessary for the development of the treatment (compare therapeutic chart, III, with tele chart, II). The

role of the psychiatrist is more complex than in other forms of psychotherapy. He and his aides have to organize on the therapeutic stage a society in miniature around the patient. The patient is the poet. His actions and moods suggest the leads.

PSYCHODRAMA WITHOUT WORDS

THE DANCE AND PSYCHOMUSIC*

We approach here new realms of the psychodrama, the realm of pantomime, the realm of rhythm, dance and music, and the realm of the (apparently) nonsensical. Methods for the exploration and development of a language-free, non-semantic psychopathology are needed. An illustration of such a method is the experimentation with the spontaneity states, with the warming up process, and with the body moving in space. We did not deal with word association primarily. No verbal process was expected. The body warmed up to a dance, eventually a dialogue grew out of it. Therefore we suggested non-semantic signs analogous to musical notes to represent a course of intermediate action, an inter-weaving of feeling complexes. The dance therapist was differentiated into two categories: the dancer-actor who dances to cure himself—auto-catharsis, and the dancer-actor who dances in behalf of a group of spectators, who co-experience with him in the dance performance—community catharsis.

PSYCHODRAMATIC APPROACH TO STUTTERING

In the course of treatment we recognized that non-semantic feeling complexes can be trained and that the exercise had an excellent therapeutic effect. It was not analytic in the usual sense, it was guided action. Rather than psychotherapy it was *body therapy*. We began to understand also that the influence of language structure upon mental processes is exaggerated, that it has not invaded the psyche without considerable resistance coming from it, that there are mental processes which grow up to maturity more or less independent from psychosemantic interaction.

Free Association of Consonants and Vowels. An aid in the recognition of these factors is the technique of nonsensical expression. The patient is told to resist the emergence of verbal utterance and to produce sounds and words which are nonsensical. The vowels and consonants are to be brought together into any possible combination as they come to him spontaneously.

*See Psychodramatic Treatment of Performance Neurosis. Psychodrama Monograph, No. 2.

This exercise is useful in the training of stutterers and stammerers. None of the stutterers and stammerers whom I have treated stuttered during this test. An illustration is Joe, 20 years old, IQ 129, gifted in mathematics and physics. He has stuttered since his parents can remember, apparently since he began to speak. After a short interview I began to work with him on the stage. He is prepared as follows: "This is a street. Walk up and down step. Look at me. I am coming towards you from another direction."

PURPOSE

Joe: I am coming towards you from another direction.

Instructions

Joe: You recognize me. Do not speak. Eliminate from your mind as well as you can the idea that you ever learned a language. Language is just like any other invention. You do not have to use it if you don't want to. If you do not like it or if you do not know how to master it well, turn it off like the radio. One day we may invent some means of inter-personal communication which is simpler and perhaps more practical to use. You can pronounce every consonant and vowel, independently from one another without stuttering. Only when you combine them to meaningful words of the English language are you inclined to stutter. Try, therefore, to combine them freely, whether the sounds make meaningful word combinations or not. (This type of spontaneously created language I called "Joe language.")

Joe: (Without starter, 30 seconds) Ope ra chee to chee, tho tra a che to pe ca, che new to ber nae tra co ta na, nae tra to tra, nae tra tra tra tra tra tra, la che tra.

(Starter: Sympathy, 25 seconds) Oh ma coue ta tu per po tu, bou tu ca li ma, ma der tu tu who cro ma to you, to you, he, ah oh oh oh.

(Starter: Anxiety, 20 seconds) Ho cru ho ho to no no no you no cu, car ca ter tra ta tu cam tu oh no ni no oh, oh, ah na no no no ru pu ne cou oh long oh li na good to cu oh ohhh.

(Starter: Anger, 35 seconds) Ta pugh pugh pugh per tra tra tra me sta pu a tu a to tra ch tu a, poor tu, tu ah, cou, coue, ta tu na cou pugh ah.

In another version an auxiliary ego acted opposite Joe as his girlfriend, both talking the "Joe language."

ANALYSIS

The above presented combinations of vowels and consonants were spontaneously produced. The patient produced them in the first instance without any intentional accompaniment of feeling. In the succeeding examples, the patient warmed up to a spontaneous state, sympathy, anxiety, and anger.

and used them as guides in the production of nonsensical utterances. An analysis of the two instances shows that in the tests with and without feeling the duration is about twenty to thirty seconds. After this time the subject already has difficulty in finding new vowel-consonant combinations. The duration varies from individual to individual but apparently within certain boundaries which recall our duration study of spontaneity states. An analysis of this test material is interesting although the results given here may be entirely accidental. In the sympathy state the leading vowel was "a", and it had the lowest number of consonants. In the anxiety state, the leading vowel was "o", and it had the highest number of consonants, more than twice as many as in the sympathy state. In the anger state the leading vowel was "u", and it was second in number of consonants. The number of the vowels "e" and "i" were in all three states comparatively low. There was a preference for certain consonants, in the sympathy state, it was for instance "t", "n" in the anxiety state, and in the anger state "t" and "p". A frequent vowel-consonant combination was 'ma', 'ta', 'ah', 'sa', in all three states.

The free combination of vowels and consonants appear to change from individual to individual. It may be valuable to follow up the extent to which the combinations are influenced by the *mother tongue* of the patients, by their "baby" language, by mental and cultural differences. The relative value of psychotherapeutic procedures can be better understood if we distinguish the non-semantic from the semantic factors of influence.

THE THERAPEUTIC PROCESS

We had in Robert a type of patient who starts easily but profits from the interpolation of resistances in the warming up process. Thus he learns how to make this process more flexible and prolong the duration of it if necessary. There are other types of patients who cannot warm up easily to a task, or at times cannot warm up at all. Instead of interpolation of resistances, they need the *intervention of appropriate starters*. Stutterers like Joe are an illustration of this type of patient. Starters have to be constantly applied to the needs of the patient, *on a level of feeling at which he is spontaneous*.

PSYCHODRAMATIC APPROACH TO CHILDREN'S PROBLEMS

I remember the case of a boy whom I treated several years ago using a psychodramatic technique. John used to beat his mother before going to bed and in the presence of guests. Several devices of treatment failed to help the boy to overcome his fits. The first role he portrayed was that of a prince

A reminder of my plan to whom he showed affinity was dressed as a queen, she acted ego, or to have as his mother, otherwise every detail was portrayed as in the actual experience: a mother putting a child to bed, or a mother serving a party and her boy entering the living room to meet the guests. The questions many would were these: whether the boy as a prince would bear the mother if she were a queen; whether his attitude toward her would be weaker, mothered or absent; whether he would not have any fit because he was thinking it is not a play.

THE INTERACTIVE PROCESS

In the first session I removed every possible resistance which might come from the role, the person acting with him, and the scenes. It was a careful elimination of role, personal resistances on the symbolic level. In later sessions we began to interpolate resistance; the queen mother was ordered to be more severe. When prepared for the role the child was influenced to restrain his words or his actions. The boy reacted favorably to the treatment after a few weeks. The symbolic level of princes and queens, boy and female, and heres was apparently the psychological level on which he was spontaneous, and therefore we hit him on the spot where he was open to influence. Gradually we interpolated new resistances, we moved him from the most extreme automatic level closer to the realities in which he lived. The next time his mother was merely a college professor, later she was the mayor's wife, a nurse, etc., until the moment arrived when we made the final move, his own mother began to act with him in these roles until a complete duplication of the home scenes were enacted by them. The fits disappeared.

PSYCHODRAMATIC APPROACH TO A CASE OF DEMENTIA PRIMOX

THE AUXILIARY WORLD

We come now to consider the type of patient with whom communication of any sort is reduced to a minimum. The more sketchy and incomplete the ego, the more articulate and thorough has to be the aid supplied from outside by an auxiliary ego. The more disturbed the mental organization of the patient seems to be, the larger are the number of aids the auxiliary ego has to contribute and the greater is the need for his initiative. Numerous auxiliary egos may become necessary and, in the case of the severe and established psychosis, the task confronting the auxiliary ego is

beyond possibility of effective treatment. The milder patient, however many aids he may need for bringing himself to a more satisfactory realization, still lives within the same world with us. In the case of the more severe patient, the reality, as it is usually experienced, is replaced by delusional and hallucinated elements. The patient needs more than an auxiliary ego, he needs an *auxiliary world*.

An illustration is a patient, William, who had been classified as *dementia praecox*. Many of the reality functions were perverted. He did not seem to feel the presence of other people in the house and he was not able to do anything with them. He repeatedly showed the desire to throw visitors, including his father, mother and brothers out of the house. He masturbated frequently and played with his excretions. He ate inconsistently and destroyed certain sorts of foods. He showed one significant trend which dominated the picture. He wrote a proclamation to the world which he wanted to save. He called himself Christ. We took this as a "lead" for the treatment.

We are considering here a type of patient who cannot be reached, either by the psychiatrist for treatment, or by anyone else, to participate in any useful occupation. He does not show signs of emotional interest in any person of his environment. He is shut in and persistently non-cooperative. The most that psychiatry and psychoanalysis have tried to accomplish is to understand these patients, to find some clues for explaining their mental experiences in the psychopathology of dreams, and the unconscious mind. But from the point of view of treatment, we had to go one step further. We translated carefully the patient's utterances, gestures, delusions and hallucinations into a poetic language as a basis to construct a poetic reality, an auxiliary world. In other words, we assumed the attitude of the poet, perhaps, still more, of the dramatist. The auxiliary egos, once acquainted with this poetic language and with the structure of his auxiliary world, would be able to act in this world, to assume roles which would fit the patient's needs, and to talk and live with him in his language and in his own universe. We regarded him so to speak as a poet who is pre-possessed at the time by the creations of his own fantasy, the creation of a mad man, a King Lear or Othello, and as we wanted to enter into the drama of his mental confusion we had to learn the grammar of his logic and assume a role which fitted exactly into his universe. The function of the auxiliary ego is to transform himself into a state of mind which enables him to produce at will a role, *if necessary similarly confused* in appearance to that which the patient experiences by compulsion.

We molded an auxiliary psychodrama around the patient. It replaced and shaped every phase of the natural environment. The only person who

that his natural role and who lived his own life in the drama was the patient. We people around him assumed roles which suited him. After more than six months with him he showed no signs of transference either to the psychiatrist or to the attendant. But he did show numerous and well developed relationships. He was indifferent to certain colors such as red and yellow. His taste was positive for blue and white. This determined the clothes he wore and the color scheme of the house. His taste for certain foods was good and bad as negative. It was positive for most fruits and green vegetables. The menu was carefully built around his affirmations, however odd they were and to cover often their pattern changed. He had a taste for a certain kind of cotton only in a poetic role and for aesthetic reasons and often even for the role in a poetic scene and position. For instance he liked to wear a shirt tucked in a corner of a room with his feet toward the door. He did not like him to kneel in any other room or in any other corner. Outside of this part and position he did not show any sign of interest in the voice of attendant.

It was the relationship of the patient which was from moment to moment the goal in the development of his psychodrama. He had been diagnosed as a schizophrenic but it appears that the 'shut-in' is more a kind of than a scientific category of conduct of this sort. It implies that the patient is withdrawn from reality. But as soon as we changed the reality for him and filled it with his psychodrama, we saw that sensations and events within it were extremely significant for him. The chart of his psychodrama can be drawn. What were all his delusions and hallucinations are probably reactions to the signals which he receives from these private networks.

THE THERAPEUTIC PROCESS

The level at which a patient is participations is the working level of the treatment. This level can be so far removed from reality that it may not include the person and physical contacts around the patient. To get Wilhelm stated we had to create a world for him which corresponds to the level on which he lives. The world which we can trust for him is a poetical, an auxiliary world. It is filled with roles and masks, with fictitious objects. As the patient progresses the roles and masks can turn more to real persons and the fictitious things more and more into actual things.

GENERAL ANALYSIS

THE ROLE OF SPONTANEITY TRAINING IN PSYCHOTHERAPY

To analyze a patient, and when this is finished to leave him to his own devices, is often not sufficient for adjustment and cure. Methods of training have been invented which develop incomplete personalities to more complete and more satisfactory functioning. The difficulty is to discover the archimedic point at which this technique can be applied effectively. We found that *the archimedic point of treatment is the psychological level of an individual on which he is truly spontaneous*.

The level on which the patient is spontaneous may differ considerably from one function to another. It may be for instance, on an immature level for one role and on a mature level for another role. Needless to say, to discover these levels, the momentary structure of each fundamental situation in which the patient operates has to be carefully analyzed. A technique of training does not emerge out of the blue but in close contact with these momentary structures and out of them. The level where the patient is susceptible to influence and to training changes from individual to individual, often from situation to situation. A technique has to be modified to meet the needs of a particular individual. The responsibility is great because a technique of training applied on the *wrong* level can be wasted effort or harmful.

The process of exploration during psychodramatic work is already a tentative phase of training. Gradually, in accordance with the need of the patient, roles are constructed which he learns to embody and situations to which he learns to adjust. For all patients who suffer from inter-personal difficulties, as in the case of Robert, the gradual and appropriate interpolation of resistances is effective.

Another method of training is the use of appropriate starters. They are important for patients who cannot easily warm up to a task or whose warming up process leads to a distorted pattern. The catatonic patient illustrates the individual who cannot warm up to a task. The stutterer illustrates the individual who warms up, but to a distorted pattern.

THE WARMING UP TECHNIQUE

Spontaneous states are brought into existence by various starters. The subject puts his body and mind into motion, using body attitudes and mental images which lead him toward attainment of that state. This is called the *warming up process*. The warming up process can be stimulated by bodily starters (a complex physical process in which muscular contractions

play a leading role, by mental starters (feelings and images in the subject which are often suggested by another person), and by psychochemical starters and food stimulation through alcohol, for instance)

The therapeutic process in psychodrama can not be understood without a full consideration of warming up techniques. As is well known in simple exercises as running, swimming, or boxing, the ability of the athlete to warm up easily and undisturbed to the task desired has a great deal to do with his speed and efficiency. I have studied the 'physiodrama' of professional athletes, their spontaneous behavior during performance situations, and found that the psychopathological characteristics of the warming up process (as used in this paper and elsewhere) ('overheated' condition, too high blood pressure, etc.) are relevant also in physical culture.

In psychodrama work and psychodrama the psychopathology of the warming up process has, if possible, a still greater importance than in physical culture. Every role needs for the sake of its proper performance to become initiated with a different set of muscles which carry along during the exercise many auxiliary systems. Every time a different role is acted, e.g. the role of the aggressor, the role of the timid, the role of the cautious, the role of the self-observed, the role of the listener, the role of the lover, etc., a different set of muscles is specially accentuated and thrown into exercise. Many roles, to be enacted, need two or more *complementary* individuals, the husband-wife or parent-child.

Through the warming up process numerous roles are brought into expression which the individual rarely or never lives through in his daily routine and which even in his night and day dreams are rarely and slightly touched. An individual in his daily routine may be limited to a small number of roles and situations but the potentialities of his personality for roles is practically infinite. We live with a small part of our personality range only, most of it remains unused and undeveloped. During the course of treatment a patient may live on hundreds of roles and situations.

I discovered when experimenting with numerous subjects that *every warming up process which covers a small range of the personality can be absorbed and for the time being undone by any warming up process which has a wider range but which includes those parts at the same time*. I have seen this principle at work so often that I feel justified to consider it as a practical rule. It is on the basis of this observation that a significant therapeutic technique developed.

I told a timid stutterer to throw himself into the state of an aggressor but to produce instead of words and phrases, non-sensical free combinations

of vowels and consonants ("Joe language"). He did not stutter during these states, apparently because in the *therapeutic warming up a wider range of his personality was made mobile than in the pathological warming up to the symptom*. The therapeutic act included the symptom-ridden speech-motoric apparatus of the patient. He threw himself into an argument with his boss. In the actual situation he stuttered heavily in the presence of his superior, reducing the range of his bodily actions. On the stage he shouted loudly at the auxiliary ego representing his employer, shaking his fists at him. He hardly stuttered and was extremely effective in the role taking. He seemed greatly relieved at the close of this session. A close analysis of what happens to the patient immediately preceding and during the production of his symptoms—stammering and stuttering—disclosed that many elements enter into the formation of the symptom and his behavior which are dictated by the momentary structure of the role which he accepts dimly, which he thinks he should act and which he identifies with himself—the role of the stammerer and stutterer into which he throws and drags himself more and more, adding to it feelings of anxiety, tensions of all sorts. He acts similarly to a person who is told by the psychiatrist to throw himself into a role at will, only that he "autosuggests" this role to himself.

Another patient, a woman of twenty-nine, had lost her natural voice since she was ten years old. She could talk fluently, but the sound of her voice was distorted. Moreover, at times she could only "hiss." When she was a child, everyone used to praise her beautiful silver voice. One day in school she was asked to recite a poem but she could not speak. She had lost her voice. However, when I told her to throw herself into the role of praying, but to use instead of words free combinations of vowels and consonants, her voice had a natural intonation. It was a surprise to her. She had not been able to produce her natural voice for many years.

Another patient suffered from a drawn feeling on the left side of his face beginning with a feeling of tension around the left nostril but including gradually the left part of the mouth and the nose, the lower eyelid, and the whole face. Sometimes, but very rarely, parts of the right face had a similarly drawn feeling. These sensations were easily precipitated by light shining upon his left face or a girl sitting on his left side. *He could free himself from these compulsory ideas if he threw his body and mind into states and roles, especially in states in which he had the role of an aggressor.* When he could yell out loud and command, as for instance in a role of newspaper boy or an executive, a wider range of his personality was thrown into the warming up process of the role and the muscular apparatus on the left side of his face which he had just used in the production of his symp-

form was also included and used in the operation of the role. Thus the other social contractions were enveloped and absorbed by this process. After such spontaneous workouts, the symptoms disappeared entirely for many hours and sometimes for days. This experience had an excellent therapeutic effect upon the patient and we began then to compare the spontaneous process of warming up to a role with the spontaneous process in the warming up to his symptoms. The more closely his process was analyzed, the more it became evident that the symptoms did not just "come" but were produced by him similar to any other spontaneous role. He acted in the role of a man who feels that he is critically watched by someone or that he must be critically watched by someone because light is shining upon his face, and that he therefore looks or may look distorted and ugly to this someone. This someone may be himself or some other person upon whom he wants to make a good impression. He gradually warms up to the state, and the more he lets himself go into it—like in any other spontaneous state—he adds to it numerous other symptoms as they fit into the role, feelings of anxiety, of disgust with himself, of despair that he will never get well. Every step farther in the role stimulates new associations in the direction of the neurotic role and the farther he is advanced in it, the harder it is for him to get out of it. As soon as the patient realized that the neurotic role does not "come" but that he produces it and that he can break its progress any time through simple spontaneous workouts, his condition began to improve.

During the study of momentary symptom production, a single factor stood out, the rapidity of the warming up and the rapid swing of associations and events in the course of spontaneous states. This confirms what I had found many years ago during my experiments with spontaneous states. Spontaneous states are of short duration, extremely eventful, sometimes crowded with inspirations. I defined them then as *bits* of time, the smallest units of time. It is the form of time which is actually *lived* by an individual, not only perceived or constructed. It is methodologically useful to differentiate it from other forms, as *spontaneous time*. Spontaneous time can be considered as the primary structure of time underlying all its concepts as astronomical time, biological time (and Bergson's *durée*), psychological time (for instance history of an individual). The high frequency of events during spontaneous time units, the crowding with acts and intentions, may be responsible for that peculiar threshold-sensation that they are "coming" from somewhere, from a meta-psychological source, from an "unconscious." Would we ever have come to the concept of the unconscious if the flow of subjective time would have been equally even, of equal intensity and of equal duration in every one of its moments? Apparently it is the too high and too low

frequency rate of spontaneous states which brought about the question. I think we can expect from their analysis a better understanding of psycho-psychological problems.

SELF AND TRANSFERENCE

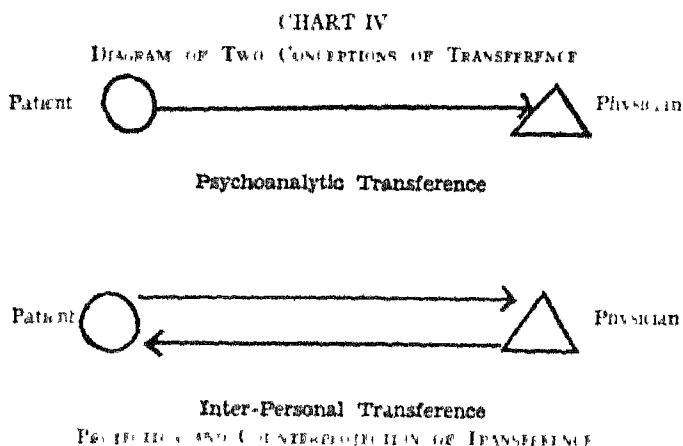
The procedure throws some light upon the distinction between transference and tele-relationship. We quote here the author of the transference concept, Professor Freud:

"A transference of feelings upon the personality of the physician . . . it was ready and prepared in the patient and it was transferred upon the physician at the occasion of the analytical treatment" (1, p. 475). As far as his transference is positive, it clothes the physician with authority and it produces faith in his communication and interpretations. (1, p. 477). His feelings do not originate in the present situation and they are not really deserved by the personality of the physician but they repeat what has happened to him once before in his life." (1, p. 477, my translation.)

This transference concept developed gradually out of hypnotism and suggestion. Mesmer and the old-time hypnotists thought that some fluid flowed from the psychiatrist to the patient and put him into the hypnotic state. Later when Bernheim showed that a patient can put himself into a hypnotic state through auto-suggestion, the conclusion was that all that mattered was the mind of the patient himself. He is the hypnotist and the patient in one. Thus the personality of the outside hypnotist or psychiatrist appeared negligible. Psychoanalysis studied the situation further and demonstrated that it is the patient who, in identifying the psychiatrist with certain fantasy products of his own, *projects* emotions into the psychiatrist. The psychoanalyst, cognizant of this mental process in the patient, makes it the basis of treatment. Spontaneity and psychodramatic work compelled us to come to a still clearer and wider view of the physician-patient relationship. In the psychoanalytic situation there is only the one who transfers whether positive or negative, the patient. There is only one pole. The psychiatrist is considered as an objective agent, at least during the treatment, free from emotional implications of his own, merely present to analyze the material which the patient presents before him. But this only appears to be so. Perhaps because only the patient is analyzed. The psychiatrist and physician, his equipment with superior knowledge, has been put into the foreground and his private personality and individual makeup underlying that role have been neglected.

This can be felt in any regular office practice. The psychiatrist is more attracted to one patient than to another, and the success of his treatments

are mysteriously uneven. He succeeds with a patient where another psychiatrist has failed, and fails with a patient where another psychiatrist easily succeeds. Such casual observations are strongly reinforced in the course of psychodramatic work. In the psychodrama all participants are parts of the analysis. We have observed during the work that the psychiatrist, like the patient, suffers occasionally from transference towards the patient. Mental processes in his own mind, related to the patient, have a definite effect upon his conduct during the psychodramatic work. The suggestions he makes to the patient, the role in which he acts, the analytical interpretation he gives, influence the outcome of the treatment. In other words we return partly to the position of the hypnotizer and the pre-analytic psychiatrist. Also, the psychiatrist projects fantasies of his own upon the patient. Transference develops on both poles. *Not only the but also transference is inter-personal.* The psychiatrist is no exception to the rule. Analysis should be made from both ends of the line. Psychoanalysts have felt this problem and have tried to free the prospective practitioner of psychoanalysis from his own personal



difficulties through an educational analysis. But the process described above can hardly disappear even after such a preparation. The prospective practitioner may have become free from transference in regard to that particular psychiatrist who analyzed him. But that does not mean that he has become free from transference in regard to any new individual he may meet in the future. He would have had to gain the armor of a saint. His armor may crack any time a new patient marches in, and the kind of complexes the patient throws at him may make a great difference in his conduct. Every

new patient produces a spontaneous relationship with the psychiatrist and no educational analysis which has been carried out at one time can preview and check all the emotional difficulties emerging on the spur of the moment. In my opinion the self-analysis of the psychiatrist is not a sufficient check on this process. Therefore the first recommendation which we made in the first days of psychodramatic work was that the psychiatrist who participates in the procedure—just as well as the patient—has to be analyzed by *others* during the treatment.

A further study and analysis of a large group of normal and abnormal individuals showed that transference plays a definite but a *limited* part in inter-personal relations. Normal individuals show selective affinities for some persons and some persons may show selective affinities for them in return. In every type of social situation, in love, in work, and in play situations, this preference for another individual or the preference of the other individual for him is in the large majority of cases at least, not due to a symbolic transference, it has no neurotic motivations but *is due to certain realities which this other person embodies and represents*. Even when the affinity is not mutual, if the affinity is one-sided, as long as an individual is attracted towards a *reality* in this other person, the factor shaping the inter-personal relationship must be a new factor differing from the mechanism of transference, unless we stretch the meaning of this concept inappropriately beyond its original meaning. A complex of feelings which draws one person towards another and which is aroused by the *real* attributes of the other person—individual or collective attributes—such a process is called a *tele-relationship*. The tele-relationship is able to clarify that part in the psychiatrist which is mysterious. A psychiatrist may be relatively free from transference but he is never free from the tele process. It may be that he is naturally attracted or naturally repelled or indifferent towards certain patients because of their actual individual attributes, and the same is true of the patients. It may therefore be because of the tele factor that he is successful with some patients and unsuccessful with others. Therefore our second recommendation is that the patient should be carefully *assigned* to a psychiatrist or attendant, that not every psychiatrist will do for every patient, that there are definite tele limitations. The tele relationship is a universal factor operating in normal and abnormal situations.

The social atom of an individual is seen as consisting of criss-cross affinities between him and a number of individuals and things on numerous levels of preference. The social environment in which the individual functions may be, and most often is, in utter discord with his socio-atomic structure. The social atom is used as a guide for techniques of person-to-person

and pre-arranging assignment. As the individual is moved nearer to certain individuals and things, and farther away from other individuals and things, a deep experience takes place in the participating subjects. It is the point where the tele turns therapeutic. The larger the number of participants, the more demonstrative is the communion. The experience is in essence the same whether 28 girls of the Hudson School Community find at their tables actually sitting near them at supper, the girls they had chosen, or 135 others moving into a new community find mutual friends as their neighbors. "It is like starting a new life." "I am so happy now"—and similar utterances are heard, indicating feelings which the verbal symbols do not adequately represent in the process. The fact that an affinity for an externalized structure does not necessarily mean that they are remnants from an infantile level of development. It means merely that there are numerous feeling complexes for which language is a poor medium.

When a patient is attracted to a psychiatrist, two processes can take place in the patient. The one process is the development of fantasies (unconscious) which he projects upon the psychiatrist, surrounding him with a certain character. At the same time, another process takes place in him—that part of his ego which is not carried away by auto-suggestion feels itself into the physician. It sizes up the man across the desk and estimates intuitively what kind of man he is. These feelings into the actualities of this man, physical, mental or otherwise, partly based on information, are tele relations. If the man across the desk, for instance, is a wise and kind man, a strong character and the authority in his profession which the patient feels him to be, then this appreciation of him is not transference but an insight gained through the tele process. It is an insight into the actual makeup of the personality of the psychiatrist. We can go even further. If, during the first meeting with the patient, the psychiatrist *has* the feeling of his superiority and of a certain god-likeness, and, if the patient experiences this from the gestures the physician makes and from the manner of speaking, then the patient is attracted not to a fictitious but to a real psychological process going on in the physician. Therefore, what at first sight may have appeared to have been a transference on the side of the patient is a true tele projection. The patient may have subjective reasons to believe that the doctor is entitled to that almighty feeling he has about himself. The better the man, the better is his chance to be cured by him.

A similar process happens between two lovers. If the girl projects into her lover the idea that he is a hero or that he has an excellent mind, this may not be at all a fictitious construction but the experience of the role he plays toward her, the role of the great lover, of the man who is going to

do great things. She is attracted to the realities of the momentary structure within him, the man before her. Even if at the start she had images of him which were unfounded, the better she becomes acquainted with him the more the transference vanishes and gives way to the tele process. The tele process is not necessarily less fantastic or less romantic than transference. The romance is based on inter-personal realities. The tele relation she has had from the start to the configuration of his mind, the rhythm of his body, the color of his hair and eyes, his social positions, etc., break forth more and more and establish the real bond between the two. Transference is a strictly subjective process within the patient or any one particular person, whereas the tele process is an *objective* system of inter personal relations. Besides the s (spontaneity) factor, it is the tele factor which acts in the cure and not transference. Transference is the factor which hinders it.

It appears that there are chiefly two reasons why the transference concept is uncritically used. I. The momentary psychological structure of an individual as it emerges spontaneously and grows in the course of the treatment is not considered sufficiently by psychoanalysts. They are too much fascinated by the idea that the feeling the patient has for the psychiatrist is an emotional hangover of past memories (4, p. 3-6) for instance, of an *Oedipus* complex. II. The approach of psychoanalysis was fully justified when it entered the field about four decades ago. The status of psychology as a science has changed since then. As long as psychotherapy was carried out for a single person, it was easily possible to take transference at its face value as an unobjective projection of a patient upon his doctor. But as soon as inter-personal therapy began to study the spontaneous interactions of many persons towards each other, it became clearer, from step to step, that the transference process itself was in many respects an expression of dream work, not of the patient this time, but of the psychiatrist.

The tele relation can be considered the general inter-personal process of which transference is a special psychopathological outgrowth. In consequence, underlying every transference process projected by a patient are also complex tele relationships. Many factors which are uncritically assigned to transference are true tele projections. As long as transference is the only crux of psychotherapeutic treatment, the personality makeup of the psychiatrist does not matter. It is sufficient if he is well analyzed and highly skilled in his specialty. But since the therapeutic tele process has to be recognized as a new and important crux for treatment the situation has changed. The other personality has become extremely important, and with it in varying degree all other personalities within the social atom of the patient. The tele structure therefore suggests a proper assignment of a person to another per-

tion or to a group to obtain the greatest therapeutic advantage. The techniques of the auxiliary ego, the techniques of assignment, the psychodrama technique as a medium of psychotherapy, especially for the infant, the child, the adolescent, the feeble minded individual, the manic-depressive, and the schizophrenic.

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THE FUNCTION OF THE AUXILIARY EGO AND INTER-PERSONAL THERAPY

INTRODUCTION

This paper presents an active form of psychotherapy in which the personal and the inter-personal problems of patients or subjects can be treated at the same time. The concept and techniques of the *auxiliary ego* are here introduced. The *primary ego*, the patient or client, is often found unable to solve a conflict which has been developed between him and *other* persons, a parent, marriage partner, employer, and so forth. He needs aid. The auxiliary ego is a therapeutic agent who provides the assistance he needs. The auxiliary ego has in this form of therapy two functions, a) as an extension of the primary ego: he is identified with him and represents him towards others, b) as a representative of the other person, *the absentee*, until the two primary subjects themselves are ready to meet. The method is illustrated in a case of inter-personal disturbance between three persons — a triangular neurosis. The function of the auxiliary ego consists in getting each member of the triad started. To get them started one must know on which level they are spontaneous. The spontaneous flow of relationship can be disturbed not only within but also between persons, and the three persons who form the neurosis are not able to act out their problems effectively. Then the auxiliary ego enters between them and prepares one for the other. This method has an unlimited field of application in the treatment of social problems. In the treatment of mental patients it breaks with the *isolated* treatment in a psychiatric or psychoanalytic office. The psychiatrist is often—because of difficult tele-relations—a poor therapeutic agent for the patient facing him. He should then try to treat the patient *intermediately*, through an auxiliary ego, a relative, friend or nurse.

INTER-PERSONAL AND TRIANGULAR NEUROSIS

A simple case which illustrates the new approach is a matrimonial problem which I had to treat a few years ago. A woman married for twenty years complained of the diminishing affections of her husband who had developed a relationship with another woman. She suffered from hysterical attacks, suicidal ideas and insomnia. Although she desired violently to win him back, she persecuted him and the other woman. She disappeared at times, but always came back home.

After the first consultation, it was evident that if her husband could give up the other woman and act towards her as he had in former years,

most of the problem would be solved. I realized that it was impossible to make her resign herself and see that she had to give up her companion of many years, her provider, and the father of her children. She did not want *adjustment* to a situation she could not endure but the *restoration* of a situation with which she had identified herself and with which she had been identified by everyone she knew since she had, as a young girl, left her parents' home - the wife of this man.

I undertook to treat this inter-personal relationship in regular sessions but with a new perspective. Instead of trying to treat her in exclusion from others, I intended to treat all individuals essential to her situation objectively. I found her isolated and rejected. Her ego was weak. She did not want me to be too objective to analyze her from her husband's point of view or the other woman's point of view. She wanted me to share her view, to feel with her, and to take an active part in behalf of the restoration of her former life situation. She wanted me to identify myself with her. She felt a great deal of ease and consolation when she discovered that I, when she assumed to be of superior strength, would aid her to achieve her aim. I took it upon myself to be and to act the part she needed, sincerely and faithfully. I, the physician, became her *auxiliary ego*. I had given up, to an extent at least, the analytical objectivity of a psychiatrist and counsellor. I became as one-sided and as narrow-minded as she was - perhaps sometimes less, sometimes more. The therapeutic advantage of the auxiliary ego consisted here in an intimate exchange of association, feelings, and ideas living through an adventurous project, all leading up to a plan of how to bring the husband back to her. An auxiliary ego has to be *convinced* that the patient is right. It is not sufficient that he *feels* his part. He has to agree and believe that the patient is subjectively right, and this is possible because every ego in its own view is right. The physician should be able to identify himself with the patient without *cheating*. *To go through the subjectivity of the patient and identifying himself with all the patient's experiences as far as organic limitations allow is the essential function of the auxiliary ego.*

The patient asked me after a few sessions to see her husband and convince him that he should give the other woman up and come back to her. The suggestion came from her. I did not suggest it. During the treatment the auxiliary ego is auxiliary to the ego of the patient. The therapeutic leads have to come from the patient. I met her husband, a banker, alone. He was still sharing the apartment with her. He admitted his love-affair, that he was not happy with his wife. He complained of inability to work and that he had tried, because of this conflict, to end his life. He

thought his death would be the best solution. Owing to his unhappiness, he felt inferior in his ability to do his work well and feared that he might lose his position as a consequence. He dreaded to think how many people would suffer from such an event, as so many people depended upon his ability to earn.

I explained his wife's situation to him. My technique consisted in presenting as accurately as possible the feelings and disappointments his wife had experienced in the course of the years - subjectively true, and therefore one-sided and uncompromising - and elaborating further certain suggestions she had only indicated. I proceeded not like an advocate who tries to influence an opponent for the sake of his client and not like a laboratory scientist who presents his findings as objectively and comprehensively as he can, but like a poet who enters with his feelings and his fantasy into the *dramatis persona* of his hero, the hero or heroine being in this case, Mrs. A. My presentation made a visible impression upon him for two reasons. On one hand, what I said contained many novelties about his wife. Apparently he knew little of what he had gone through. She rarely talked to him, and when she did, it was in moments of mutual, angry excitement. He either had distorted memories of these moments or he did not remember them at all. *I proceeded in the course of the session, to aid his memory and to bring back, piece by piece, the things he had forgotten, things she had done for him, words she had said to him, and promises he had made in return.* This technique should be of particular interest to the individual-centered psychoanalyst who comes often to a deadlock in the course of treatment.

It made an impression upon him that a person other than herself knew and described her mental experiences insofar as they were related to him. After a pause, he asked me whether I thought that she was mentally ill. I told him that she thought the same about him. But whether it were the case or not, to discuss this was beside my function. I gave him to understand that I would not make such a diagnosis for him so that he might be able to discard his guilt with the gesture "My wife is mentally ill." My function, I explained to him, was not to analyze his wife and disclose the causes of her mental difficulties to her so that she might find some adjustment by herself. My function also was not to observe her carefully and make a diagnosis of her personality problems which I could bring to him. On the contrary, my function was primarily to present to him, or to any other person she might indicate, her actual psychological situation, after having attained the fullest possible identification with her feelings

When he brought up a number of problems which I could not answer correctly, I returned to a new session with her. As she also continuously wanted to know more about how he thought and felt about her, or about this or that situation, *my technique consisted in having alternating sessions with her and with him, always bringing to each party an accurate and subjectivistic report of what they had to say in regard to each other.* The more I went on with the work, the more I realized that I was not treating one person or the other, but an "inter-personal" relationship, or what one may call an "inter-personal neurosis." To call the relationship between psychiatrist or analyst and patient "inter-personal" is misleading, it certainly is not inter-personal *treatment*, only *one* person is treated—the patient. The relationship between psychoanalyst and patient consists of projections from the patient towards the analyst and of projections from the analyst towards the patient. These two projections may never meet and merge into one flow of feeling—*an inter-personal relation.*

The work appeared to revolutionize all customary concepts of psychiatric treatment. I recognized that in a truly inter-personal neurosis, the neurosis exists only as long as a controversial flow of emotions between two persons exists. In our case, Mr. and Mrs. A may or may not be neurotic individuals. Their inter-personal neurosis co-exists and is an additional status. It is methodically advisable to study it as a special unit. If Mr. A could adjust himself to Mrs. A's needs and aspirations, she would obtain the inter-personal balance she enjoyed before the present conflict set in. This inter-personal balance, the balance between her and Mr. A, would be resurrected regardless of whatever personality difficulties, neurotic or otherwise, she might continue to have. Mr. A, in turn, would attain his inter-personal balance or his inter-personal neurotic signs would gradually vanish if Mrs. A ceased to pursue him with her feelings of jealousy, with her appeals to his pity and to situations and obligations of the past, if she would free him from the present relationship so that he might be able to pursue openly his love for the other woman and marry her. Whatever personal difficulties he did have otherwise would of course continue to express themselves even after this inter-personal neurosis was resolved.

In the case of Mrs. and Mr. A the technique of the auxiliary ego came to a critical moment. Just as I presented him with her hidden feelings in regard to him, and re-established, step by step, his memory in regard to past scenes they had lived together, and in regard to her present situation, I brought back to her reports from him which aided her to re-establish in herself certain moments they had lived together, and his present situation. A difficulty gradually developed. He sometimes tried violently to win me

to his side, to make me *his* exclusive auxiliary ego, so to speak. He hoped, then, that she would lose me as such, and that he would be able, perhaps, to be given liberty from his wife through my aid. In turn, she had developed a fear that she might lose me, that he might be able to influence me. "He knows how to make people like him," she said, "and you may learn to like him better than me." It was then her wish that I should stop seeing him for the time being.

Before I continue the report of this case, some remarks regarding the auxiliary ego technique is necessary. First, it has to be understood that the process of active identification of the auxiliary ego with the primary ego (the subject) is never complete. It has its organic and its psychological limitations as well. Mrs. A frequently complained that I did not accurately report to her husband a certain scene which repeats itself every day at home, but that I had distorted its meaning. Evidently I often interjected some elements of my own ego into the report coming from that part of my ego which was not yet able to dissolve into hers. Once or twice I had a similar experience with him in regard to what I had said as auxiliary to her. Besides personality equation which might interfere, tele factors came into operation here. Even the best technique of the auxiliary ego cannot work satisfactorily if the auxiliary ego and the ego of the patient do not "click."

Another point in the technique is that it has to be constructed differently in each inter-personal relationship. Where the inter-personal neurosis is not complicated by a third person the procedure is simple. The two persons interrelated are treated in alternating sessions until a balance of interrelationship is obtained. But in the case of Mrs. A the problem transcended two persons. When a deadlock developed between him and herself, she wished me to contact the other woman. Perhaps she could be persuaded to give her husband up.

Mrs. K, a widow, cried when she came to the interview. She said she feared that some harm might come to her or to her family. During the last two years she had retired more and more, and rarely went to parties as she used to because of what people might think of her, rightly or wrongly—fear of "grapevines." She rarely met Mr. A. Letters were almost their only contact. She was afraid to meet him because her parents were firmly opposed to any possible relationship between them. She had met Mrs. A a few times. In two sessions I answered her questions, gave her a picture of Mrs. A's situation as well as that of Mr. A, recalled to her certain scenes she had had with Mrs. A, as well as with Mr. A and discovered inconsistencies in regard to their respective reports of similar scenes which I tried to clarify. When I again saw Mrs. A, I brought to her a

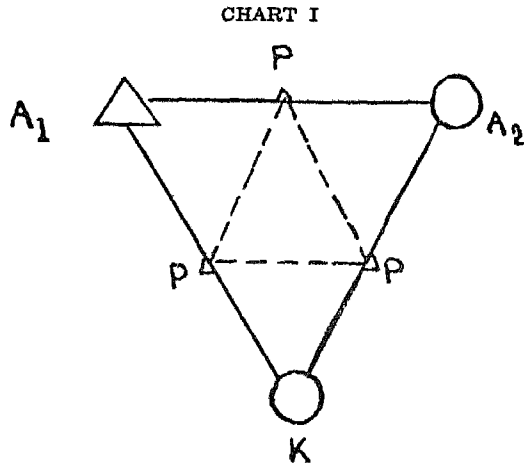
duplication of the feelings Mrs. K had in regard to her and to her husband, and when I met Mr. A I brought to him a duplication of the feelings both had for him. Mrs. A insisted that the relationship was not love, that it could be broken. This woman had just bewitched him. Mr. A loved only her, Mrs. A, whatever he and Mrs. K might say to me. He was under this woman's spell.

The whole process of treatment had come to a stop. There were three persons, each determined to persist in his or her position. Mrs. A loved Mr. A; he disliked her in return but loved Mrs. K, who loved him in return. A further analysis showed that the relationship was still more complex. Mrs. A loved Mr. A only in some roles, she hated him in others. She loved him as the only sexual companion she had ever had. She loved him as the father of her children and head of the family and as her provider and supporter. Her position in the community had been based on this for years, all the people she knew and he knew regarded her in that position. She had become rigidly fixed to this position in the group. She did not want it altered. She felt that he belonged rightly to her, that he was her property. But in some respects she was indifferent to him, in regard to his work and his work relations. She hated him because he loved Mrs. K. He robbed her of some of the time and money which belonged rightly to her. She disliked him also because he showed less affection to her children. This meant on one hand, a "loss" of prestige. On the other hand, she thought that he liked the children less because he liked her less and she feared that he might wish to have children with the other woman, the new woman whom he loved. She had five children; one boy siding with the father, four others siding with the mother. Mr. A, in return, disliked Mrs. A as a sexual companion and also as head of a family which had banded against him as an enemy. This illustrates how complex the tele¹ relation between two persons such as Mr. and Mrs. A can be. It is neither positive or negative. It is in some respects positive, in some respects negative and in some others it is split. The tele relation of the triangle between Mr. A, Mrs. K, and Mrs. A was similarly complicated. The total system

Tele is defined as a feeling process projected into space and time in which one, two, or more persons may participate. It is an experience of some real factor in the other person and not a subjective fiction. It is rather an inter-personal experience and not the affect of a single person. It is the feeling basis of intuition and insight. It grows out of person-to-person and person-to-object contacts from the birth level on and gradually develops the sense for inter-personal relationships. The tele process is considered therefore the chief factor in determining the position of an individual in the group.

of interaction produced a clinical picture which can well be called a "triangular neurosis"

When I reassumed treatment I became auxiliary ego to each member of the triangle (See Chart I) *The effect of the treatment was first that*



A1—Man

A2—Wife

K—Other woman

P—Psychiatrist

Diagram of function of psychiatrist as auxiliary ego. A1, A2, and K are three patients. The solid lines represent the inter-personal relationships of the three people. P is always the same psychiatrist in this case, acting first as auxiliary ego between A2 and A1, A2 and K, and A1 and K, K and A1 and K and A2. In the performance of this function a general catharsis for the interrelationships is achieved.

each partner had a full picture of every other partner, second, a full picture of their inter-personal relation and, finally, the realization of the organic logic of the affinities which produced the triangle. The dynamics of the treatment brought about spontaneously a solution for the triangular neurosis. Mr. and Mrs. A separated upon mutual agreement and he joined and married Mrs. K.

THE FUNCTION OF THE AUXILIARY EGO IN INTER-PERSONAL RELATIONS

The personal situation of the auxiliary ego has to be differentiated from its function. However much he may have become auxiliary, however deeply he may approximate the ideal of unification, the unity is never complete owing to organic and psychological limitations. The degree of organic and psychological limitations varies. *The mother is an ideal auxiliary ego to the baby with whom she is pregnant.* She still is that after

the birth of her infant whom she nurses and for whom she cares, but the organic and psychological gap manifests itself more and more after the infant is born. The mother is an example of an instinctive auxiliary ego. Either the auxiliary ego includes the person to be aided—inclusion of the weak infant's ego by the mother ego—or it is itself included. In the latter case the auxiliary ego is weak and the person aided is strong. This relationship is often forced, as in self-master relationship, and has the mark of exploitation.

The auxiliary ego can take good advantage of the gap between himself and the person to be aided. As only a part of his ego is spent in the process of unification, *a part of it is free to act in behalf of the other person beyond what he can do for himself.* In the case of a psychiatrist, if he were the true 'double' of the patient, his contribution would be of little value. With the unattached part of his ego, for instance when he moves from Mrs. A to her husband, he can prevent the situation of Mrs. A in a more integrated and complete way without being the object of Mr. A's emotional wrath, as Mrs. A would be. The function of the auxiliary ego is therefore to attain unity with a person, to absorb the patient's wishes and needs and to operate in his behalf without being able however, to become identical with him.

Another form of the auxiliary ego is the case of the leader-group relation. True leadership operates like an auxiliary ego. A good illustration is the religious leader. He concentrates on a few individuals. He moves from one individual to another, and is auxiliary to each of them until the degree of necessary identity is attained—and until, through his auxiliary function, every individual of the group has developed identity with every other member. As far only as he has obtained unity with each of them separately and he has ascertained that they have become auxiliary to one another, is he a true leader. The larger the group is, the more difficult it becomes to be the auxiliary ego of each member directly. Judas is a sample of a member who for some reason remained unreached and unassimilated by Jesus. His isolation led to conflict.

The larger the chain of individuals whose balance of interrelation is disturbed, the more difficult becomes the task of the psychiatrist whom they have employed for treatment. In the case of Mrs. A, three people were involved. The controversial flow was almost entirely between the three persons. The chain of outside personal influence which ran to each of them—the psychological networks—had little significance. Their interrelational catharsis was gained without bringing the networks into the treatment. In some cases however, the sensitivity of the patient for the controversial flow of the tele through the persons of the networks is great,

and the anxieties of the patient are due to network "work." To reach a network numerous people may belong, living in different parts of the country. It means that the work of the auxiliary ego has to be enlarged farther than in the case of the A's, although it consists essentially in the same procedure—the alternate shifting of the psychiatrist from one person of the network to another for the purpose of reconstructing their relationship with the patient. The healing influence, a network catharsis, comes here from the networks, the source of the disturbance.

Usually the persons belonging to a network can be easily traced. Some parts of the network are extremely lucid in the patient's mind, other parts are sketchy. The patient can be brought to remember piece by piece the string of persons leading up to a *key individual*—the carrier of a significant emotional message—and a key situation. The older a person is, the larger may be the number of acquaintances which he has made during a life-time and the key individuals who have stirred him up. The networks may be so extended that parts of them are not remembered. The situation may be that the class of individuals interrelated shows difficulties of such a range and character that to treat their networks would mean to treat the community as a whole.

THE FUNCTION OF THE AUXILIARY EGO IN COMMUNITY RELATIONS

The method of the auxiliary ego must be modified to meet the demands of a socially unbalanced community. This is the case in a prison, a mental hospital or any closed community. In cases like these there are many patients to be treated at the same time, every patient being afflicted with a particular problem and their interrelations becoming so numerous that the psychiatrist is unable to treat them directly. The function of the psychiatrist once again had to be considered. First we had found him wanting because of the rigid office situation and because of his rigid role of physician. To overcome this handicap we developed the function of the auxiliary ego which we hoped would enlarge the scope and increase the flexibility of his role. Throughout all this we cherished the notion that the psychiatrist alone is the healer, that all the therapeutic tele derives from him and nowhere else is so concentrated and effective. However, sociometric studies²

²Sociometry is a study of the actual psychological structure of human society. The structure is rarely visible on the surface of social processes, it consists of complex inter-personal patterns studied by quantitative and qualitative procedures. One of the procedures used is the sociometric test which determines the affinities of individuals for one another in the various groups to which they belong. A psychological structure of inter-personal relations is disclosed by the test which often differs

revealed to me that a great deal of the therapeutic tele is distributed all over the community and that the question was only to make it effective and to guide it into the proper channels. The therapeutic tele is extremely selective. A patient may be sensitive to one person, insensitive to another. Viewing the community with the aid of sociometric charting, the physician saw it filled with hundreds of little psychiatrists who did not function, or functioned in the wrong direction. Positive tele occurs in any relationship between two or more persons which is produced by the affinity between some factor in one person and some factor in another person actually operating at the moment. Negative tele occurs in any relationship between two or more persons involving repulsion based on some factor in one person and some factor in another person actually operating at the moment. If a person is attracted towards a certain person, and if this person is far from him, in another group, the moving of this person towards him produces an experience in both which is *therapeutic tele*. This is the case even if the persons do *not* know each other. If they are true correspondents able to fulfill a mutual need, therapeutic tele is possible. The chief psychiatrist had to be put out of action to be removed from the scene; he became an *auxiliary ego at a distance*. His function reduced itself to deciding who might be the best therapeutic agent to whom, and aid in the picking of these agents. The psychiatrist in this development became small and insignificant as a person. He had lost all the insignia of all-mightiness, of personal magnetism, and statu of counsel. *The face-to-face physician had become a physician at a distance*. He adjusted his function to the dynamics of a tele world. The new function can well be compared with our idea of God, the original face-to-face God in whom man was included before the act of creation and who was near man during the creation. But also He, the first and the greatest auxiliary ego was removed from the scene, or removed himself silently from it. He moved to such a distance from our lives, perhaps, so that we might feel His interference as little as possible, the Aristotele of the whole world.

considerably from the relations which they actually have in the groups. On the basis of this finding a technique has been worked out which moves the individual from his established position to a position in the same group or to another group which he more tolerates him. The leads for this change are given by the individual towards whom the individual is spontaneously attracted, or who are attracted to him. If the change of position is made on the basis of a thorough-going quantitative and structural analysis of the groups in a given community the procedure is called *recreating a community*.

Another technique is a tele process in which numerous persons take part but which is predominantly affected by an individual who is apparently in no position of social influence or popularity. He is the true focus of influence.

SUMMARY

Let us recapitulate the leading points of this new technique. Formerly in the treatment of patients whose mental disturbance appeared as an interrelationship product, the other person or persons who participated in the conflict were left out of the treatment, at least from its dynamics. The patient was treated singly and the wife, the lovers, the employer, the son or the daughter remained "fictitious" in the course of the treatment. It was assumed that if the patient were well and adjusted, he would take care of these relationships him-self without assistance. But in fact, for certain patients who come for treatment, this seems impossible. They do not come to the psychiatrist so that they may be helped in sublimation and learn to accept an ugly reality, but to meet a conflict in which another person has an essential part. This situation forced us to the first step in the new technique. The psychiatrist became an auxiliary ego. He was still the main agent in the process of healing. He saw a social conflict or a mental disease developing through the interaction of other persons. When the interrelationships involved in a social neurosis became too large, he was compelled to make use of other therapeutic agents and to remove himself from the scene to become an auxiliary ego at a distance. The new techniques, however, appeared in one respect insufficient. The auxiliary ego was always one and the same person, enacting one and the same rôle. Some of these patients whose warming up process⁴ was disturbed in the tests of their life reality needed a treatment-situation in which the complete operation and function of every possible relationship was lived through. What they needed was to dramatize their psyche before our eyes not only singly, but acting with all the actual persons involved in the scenes. The nearest thing would be to arrange, after the auxiliary ego technique has prepared each of them sufficiently, that the partners in the conflict *meet* so that they

⁴ "Warming up process" is a technical term deriving from discussion of spontaneity work. Spontaneity is explored through the study of spontaneous states, states or rôles into which an individual throws himself suddenly. Such states are usually felt by the acting subject as completely novel experiences, frequently, in fact there is no concrete precedent in the life history of the subject for the rôle portrayed. A stenographer may be called on to express anger in the rôle of a policeman. These spontaneous states are brought into existence by various starters. The subject puts body and mind into motion, using body attitudes and mental images which lead to the attainment of the state. This is called the *warming up process*. The warming up process can be stimulated by bodily starters (a complex physical process in which muscular contractions play a leading rôle), by mental starters (feelings and images in the subject which are often suggested by another person), and by psycho-chemical starters (artificial stimulation through alcohol, coffee, for instance).

may themselves enact certain emotional states and scenes which still remain unresolved and inexplicable. But the move of letting Mr. A meet Mrs. A, Mrs. A meet Mrs. K, Mrs. K meet Mrs. A in the presence of a psychiatrist is full of dynamic complications which, if seriously considered, open a revolutionary chapter in psychotherapy.

The therapeutic process flowed through a chain of four persons, Mrs. A, Mr. K, Mrs. K, and the psychiatrist. The position of the psychiatrist in the chain was unique. The point of the procedure was not so much to produce catharsis through his therapeutic relationship with the patient as *to aid in producing a catharsis between the actual partners in the conflict, man, wife, and the other woman*. The relationship of the patient to her auxiliary ego can well be compared with the relationship between the dramatic poet and the actor who embodies the hero of his play. The more he is able to throw himself into the role and to eliminate himself the more he will be in the spirit of the poet. Similarly, the psychiatrist will be the more in the spirit of the patient the more he is able to eliminate himself and to play the role as he sees it. Only the role is here not a character outside of the poet. The patient, the poet and the role are one. In a sense, he, the auxiliary ego, has to play the patient's part, just as a poet may be a poor actor of his own hero, she, the patient, is a poor actor of her own self. She needs an auxiliary to act her part more articulately, more completely, and more suggestively than she has been able to do. In the course of the process the moment arose when the psychiatrist had to act in the same manner in behalf of the second and the third party in the conflict as their auxiliary ego towards the two other participants in the conflict. He is interpolated at three different intervals between them (see Chart I). There were actually three, patient in the situation and not one. They started a play together. It had become a bad play. The auxiliary ego was a player who came to their rescue. The strategic turn in the therapeutic process was the moment, when the auxiliary ego began to remove himself and his aid more and more from the situation urging and fostering systematically a therapeutic relationship between the partners in the conflict themselves. In the finale he watched the development from a distance and stepped in at times as a prompter in a play, but *they* were the actors, it was their drama, the catharsis was the result of the tele-drama between them.

